

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1996

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12-13-43-12-21-43
(Specify whether years, months or days) unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1013 Charlotte
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JOHN JENKINS

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race 2 Negro 6. (a) Single, widowed, married, divorced 2 Widower
6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 1861
(Month) (Day) (Year)

8. AGE: Years 82 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Carrollton Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

MOTHER, FATHER { 12. Name unknown
13. Birthplace 9
(City, town, or county) (State or foreign country)
14. Maiden name 9
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address Gen. Hosp. #2

17. (a) 13 removal (b) Date thereof 12 28 '43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation K.P. Grant B.D.

18. (a) Signature of funeral director H. C. Grant
(b) Address 1513 Forest

19. (a) 5-2-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21
year 1943 hour 3:15 minute P. M.

21. I hereby certify that I attended the deceased from December 13
1943 to December 21, 19 43
that I last saw him alive on December 21, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Acute congestive failure Duration

Due to Sclerotic type heart disease with generalized Decompensation

Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: DUPLICATE

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? _____ Means of injury _____

23. Signature N. E. Brown (M.D. or other)
Address Gen. Hosp. #2 600 E. 22nd Date signed 4-29-44

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.