

0. 2
-43
7-39
K37823

FILED JUN 3 1944
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2331

1. PLACE OF DEATH:

(a) County Kansas

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Wheally Provident Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 26 days
Specify whether

In this community 30 years
years, months or days

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. 1024 East 19th Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Charles Kay

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
year 1944 hour 17 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 22, 1944 to May 28, 1944

4. Sex Male 5. Color or 2 colored

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lou Kay 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February - ? 1866
(Month) (Day) (Year)

that I last saw him alive on May 18, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute uremia Duration _____

8. AGE: Years Months Days If less than one day

78 3 - _____ hr. _____ min.

Due to Following prostatectomy

Due to _____

9. Birthplace Stewartsville Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Houseman

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Large hypertrophied prostate

Of autopsy 1370

11. Industry or business _____

12. Name Warner Kay

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Sarah

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Laura Clark

(b) Address St. Joseph, Missouri

17. (a) burial (b) Date thereof 5/31/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery
Starkins Bros.

18. (a) Signature of funeral director Lydia

(b) Address 1729 Lydia

19. (a) 5-31-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____ (Specify type of place) (e) Month of injury 5

23. Signature E. J. Marshall (M. D. or other)
2101 1/2 Street Date signed 5-31-44

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..... *J. Manlove*.....
Licensed Embalmer No. *3994*.....
P. O. Address. *2503 Highland*.....

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.