

FILED MAY 25 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2171

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 425 S. Jackson  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 Years (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 425 S. Jackson (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-16 day \_\_\_\_\_  
year 1944 hour 11:30 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from 5-13-44 to 5-16-44 1944  
that I last saw him alive on 5-16 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Liver and lungs  
Duration \_\_\_\_\_

Due to N.M.O.  
Due to \_\_\_\_\_

Other conditions: 47A  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature James M. Walker (M. D. or other) \_\_\_\_\_  
Address 1424 Jasper Ave. Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME George Washington Steel

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillie E Steele 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased July 10 1868  
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 56  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mercer Co Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name James M Steele

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

14. Maiden name Jane Richmond

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

16. (a) Informant Albert Steele

(b) Address Sandusky Ohio

17. (a) Removed (b) Date thereof 5 19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dresden Mo.

18. (a) Signature of funeral director B.F. Parker

(b) Address La Monte Mo.

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

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

MOTHER FATHER

---

---

**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.....

*B. F. James*

Licensed Embalmer No. *1592*

P. O. Address.....

*Rammond*

**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.**