

FILED AUG 9 1944

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **3106**

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

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 **7-11-44-7-24-44**
(Specify whether **13 years** in this community 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. **2601 Highland**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **17**

3. (a) PRINT FULL NAME **HURD ADRINE**

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

4. Sex **Male** **5. Color or race** **Negro** **6. (a) Single, widowed, married, divorced** **Single**

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

7. Birth date of deceased **October 8 1900**
(Month) (Day) (Year)

8. AGE: Years **43** Months **9** Days **16** If less than one day _____ hr. _____ min.

9. Birthplace **Rome Ga.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business _____

12. Name **John Adrine**

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

14. Maiden name **Sallie Whitehead**

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

16. (a) Informant **Record Clerk**

(b) Address **General Hospital No. 2**

17. (a) (b) Date thereof **7/31/1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Blue Ridge Lawn Cem.**

18. (a) Signature of funeral director **H. B. Moore**

(b) Address **1820 E. 18th St.**

19. (a) (b) Registrar's signature **T. E. Brown**
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24** year **1944** hour **9:20** minute **P.** M.

21. I hereby certify that I attended the deceased from **July 11** 19 **44** to **July 24** 19 **44**;
that I last saw him alive on **July 24** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Advanced Pulmonary Tbc.**

Due to _____

Due to _____

Other conditions **13k**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature **J. C. Brown** (M. D. or other)
Address **Qu. No. 2 600 E. 23** Date signed **7/26/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 A. T. MOORE

Licensed Embalmer No. 948

P.O. Address Kansas City

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.