

FILED SEP 7 1944

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3365

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: K. C. General Hospital No. 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 21 days

In this community unknown

(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City

(d) Street No. 116 1/2 W. 5 St.

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Franklin Grant

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive 1864

7. Birth date of deceased Nov. 1

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>9</u>	<u>3</u>	hr. min.

9. Birthplace Ky. /

(City, town, or county) (State or foreign country)

10. Usual occupation Landscaping

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

MOTHER FATHER

12. Name Simon Grant

13. Birthplace Ky. /

(City, town, or county) (State or foreign country)

14. Maiden name Mary Wilson

15. Birthplace Ky. /

(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K. C. General Hosp. #1

17. (a) Burial (b) Date thereof Aug 16-44

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Field

18. (a) Signature of funeral director Wm. A. Johnson

(b) Address Wiley Matthews

19. (a) 8-15-44 (b) T. E. Brown (123)

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4

year 1944 hour 1 minute 5 P. M.

21. I hereby certify that I attended the deceased from June 12 1944 to August 4 1944

that I last saw him alive on August 4 1944

and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease with arterial hypertension

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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? \_\_\_\_\_

23. Signature A. E. Weber (Specify type of plate) (M. D. or other)

Address Med. Dir. Gen'l Hosp. Date signed 8-15-44

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

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**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.**