

FILED NOV 13 1944

Registration District No. 749

Primary Registration District No. 1002

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: 602 BENTON BLVD
DELORA HOME FOR ELDERLY PEOPLE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 YEARS 5
In this community 30 YEARS
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY 42
(If outside city or town limits, write "RURAL")
(d) Street No. 622 BENTON BLVD
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DR. EDWIN R CURRY

3. (b) If veteran, name war No 3. (c) Social Security No. NO. IVE

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife MRS. unknown CURRY 6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 75 Months unknown Days unknown If less than one day hr. min.

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

10. Usual occupation RETIRED - 15 YEARS

11. Industry or business PHYSICIAN

12. Name CURRY

13. Birthplace unknown (City, town, or county) (State or foreign country) 9

14. Maiden name unknown

15. Birthplace unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant MRS. EMMA FRAME (b) Address 6435 WYANDOTTIE STREET

17. (a) CREMATION (b) Date thereof OCT-28-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMER'S SONS
D. H. Newcomer's Sons

18. (a) Signature of funeral director D. H. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD

19. (a) 10-27-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 26 TH
year 1944 hour 1 minute 00 AM.

21. I hereby certify that I attended the deceased from 10/15
1944 to 10/26 1944
that I last saw him alive on 10/25 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration at

Due to Actual Poisoned

Due to 8301

Other conditions: no
(Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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) (b) Means of injury no

23. Signature [Signature] (M. D. or other)

Address 6-8-11th Date signed

Walt's Belg

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. C. Newcomer Jr*
Licensed Embalmer No. *4043*
P. O. Address *A. C. Mo*

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.