

FILED NOV 13 1944

Registration District No. 174

Primary Registration District No. 1002

Registrar's No. 4283

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: Gen. Hosp. #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-14-44-10-24-44
(Specify whether years, months or days) 3 years

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. 2017 E. 18th St. Apt. 4
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ?

3. (a) PRINT FULL NAME SIE EDWARDS

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 Married
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased January 10 1882
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 14 If less than one day hr. min.

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

10. Usual occupation Unemployed

11. Industry or business NONE

12. Name DONT KNOW

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

14. Maiden name DONT KNOW

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) BURIAL (b) Date thereof 10-27-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HIGHLAND

18. (a) Signature of funeral director Hyman Greenstreet

(b) Address 1819 E. 15th St. K.C. Mo.

19. (a) 10-26-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24
year 1944 hour 2:20 minute 4 A. M.

21. I hereby certify that I attended the deceased from Oct. 14
19 44 to Oct. 24 19 44

that I last saw him alive on Oct. 24 19 44

and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Vascular Accident. Duration

Due to Hypertensive type heart disease

Due to 93d

Other conditions (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:

(c) 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?

(e) Means of injury

23. Signature D. E. Brown (M. D. or other)

Address Gen. Hosp. #2 600 E. 22nd Date signed 10-24-44

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

MOTHER, FATHER

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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 *John G. Flynn*

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th Str K 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.