

FILED NOV 13 1944

4240

Registration District No. 177

Primary Registration District No. 1002

Registrar's No. _____

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:
5100 PASEO
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 15 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY 48
(If outside city or town limits, write "RURAL.")

(d) Street No. 5100 PASEO 3
(If rural, give location)

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

If yes, name country _____ 0

3. (a) PRINT FULL NAME MR. JOSEPH HAROLD HOPE, SR.

3. (b) If veteran, name war WORLD WAR I

3. (c) Social Security No. 486-01-2101

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER, day 21 ST
year 1944 hour 1 minute 40 A. M.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. MARY BELLE HOPE

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased DECEMBER - 7 - 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-6, 1940, to 9-22, 1944;

that I last saw him alive on October 20, 1944;

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

Immediate cause of death myocardial infarction

Duration 4 hours

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>10</u>	<u>14</u>	hr. _____ min. _____

Due to Coronary artery occlusion 4 hours

Due to Coronary artery sclerosis (arteriosclerosis) 2 years

Other conditions none

(Include pregnancy within 3 months of death)

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

10. Usual occupation RETIRED G.M.S. BRANCH SECY ASSURANCE CO.

11. Industry or business SUN LIFE INSURANCE CO.

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name JAMES WALTER HOPE

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

14. Maiden name ELLA RAGSDALE

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

16. (a) Informant Mrs. Mary Belle Hope

(b) Address 5100 PASEO

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof OCT 24 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Monica

18. (a) Signature of funeral director D. V. Newcomer's Sons

(b) Address 1401 BRUSH GREEN BLDG.

19. (a) OCT 23 1944 (b) J. E. Brown
(Date received by registrar) (Registrar's signature)

(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 Graham Asker (M. D. or other) MD

Address 1220 Pop. Bldg. Date signed 10-21-44

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

MAR 29 1949

NOV 24 1944

FEB 18 1945

Professional Body

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

Oscar Hordley

Licensed Embalmer No.

Kansas City

P. O. Address

Kans. 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.