

FILED DEC 9 1944

Registration District No. 149

Primary Registration District No. 1002

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: 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 15 days
(Specify whether 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. 6425 Penn
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Stewart Glenn

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

4. Sex Male 5. Color or race White 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 Nov. 16, 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Child

11. Industry or business _____

12. Name David Glenn

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

14. Maiden name Leah J. Stewart

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

16. (a) Informant Dr. David Glenn

(b) Address 6425 Penn

17. (a) removed (b) Date thereof 12/3/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbus Mo

18. (a) Signature of funeral director Dora Mayberry

(b) Address 2315 Lincoln

19. (a) 12-2-44 (b) T. E. Brown (R)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 2
year 1944 hour 1 minute 20 A. M.

21. I hereby certify that I attended the deceased from Nov. 16, 1944, to Dec. 2, 1944
that I last saw him alive on Dec. 2, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Marasmus
Due to Inability to utilize food
Due to _____

Other conditions emphalitis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy None
PHYSICIAN 161 R
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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature A. E. Upster (M. D. or other) MO
Address Med. Dir. Gen'l Hosp Date signed 12-2-44

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

MOTHER FATHER

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.....

Roy E Snow

Licensed Embalmer No..... *2560*

P. O. Address..... *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.