

FILED DEC 22 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5102

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:
General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether years, months or days) 40 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. 4122 Harrison
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James F. Cheek

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 Widowed
6. (b) Name of husband or wife Mrs. Emma Alice Cheek 6. (c) Age of husband or wife if alive *** years
7. Birth date of deceased 3 20 1866
(Month) (Day) (Year)

8. AGE: Years 88 Months 8 Days 25 If less than one day hr. min.

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

10. Usual occupation Carpenter, Retired

11. Industry or business _____

12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Irene Schambach
(b) Address 4122 Harrison
17. (a) Burial (b) Date thereof 12-18-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills
18. (a) Signature of funeral director Mrs. C.L. Forster
(b) Address Kansas City, Missouri

19. (a) 12-16-44 (b) T. E. Brown
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 15
year 1944 hour 9:01 minute A M.

21. I hereby certify that I attended the deceased from _____
to _____
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Coronary sclerosis

Due to Fractured Right hip

Other conditions 186 1/8
(Include pregnancy within 3 months of death)

Major findings: Of operations History of Impaction
Of autopsy see

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 123
(b) Date of occurrence 12-11-44
(c) Where did injury occur? R. C. Jackson, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work? no (Specify type of place) (e) Means of injury fall

23. Signature James Walker (M. D. or other) Walker
Address 1924 1/2 W. 11th Date signed 12-15-44

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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 Stephen A. Redman

Licensed Embalmer No. 21237

P. O. Address H.C. 2nd

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.