

FILED MAY 26 1945

Registration District No.

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution General Hospital #2
(d) Length of stay: In hospital or institution 3-9-45-3-29-45
In this community 24 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 916 Indep.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME HENRY E. HALL

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 Widowed
6. (b) Name of husband or wife unknown 6. (c) "Age of husband or wife if alive" 1867
7. Birth date of deceased October 25

8. AGE: Years 77 Months 5 Days 4 If less than one day hr. min.

9. Birthplace Georgia

10. Usual occupation none

11. Industry or business

12. Name Edward Hall
13. Birthplace N. C.
14. Maiden name Sarah Brown
15. Birthplace Georgia

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 5-9-45

(c) Place: burial or cremation Deeds

18. (a) Signature of funeral director Wm A. Holmes

(b) Address City Mortician

19. (a) 5-10-45 (b) Heraldine Holmes

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 29 Year 1945 hour 3:30 minute P
21. I hereby certify that I attended the deceased from March 9 to March 29
that I last saw him alive on March 29 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerotic Type Heart Disease with Decompensation

Due to

Due to

Other conditions 93-d
(Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of injury)

23. Signature [Signature] (M. D. or D. O.)
Address Gen. Hosp. #2-600 E.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

Not Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed..... *Am A. [Signature]*

Licensed Embalmer No. *3089*

P. O. Address..... *TC 720*

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.