S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2363

1. PLACE OF DEATH:

(a) County: Jackson County

(b) City or town: Kansas City, Missouri (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Devine Clinic 918 Oak St., Kansas City, Missouri (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community 22 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City, Missouri (If outside city or town limits, write "RURAL")

(d) Street No. 3602 Indiana Ave, Kansas City, Mo (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: Amond J McKenzie

3. (b) If veteran, name war: None

3. (c) Social Security No. None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Bertie M McKenzie

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

7. Birth date of deceased: ~~XXXXX~~ 12 (Month) 17 (Day) 1866 (Year)

8. AGE: Years ~~79~~ 78 Months 5 Days 14 If less than one day hr. min.

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

10. Usual occupation: Retired

11. Industry or business: Street car Operator

FATHER 12. Name: John Mc Kenzie

FATHER 13. Birthplace: (City, town, or county) Illinois (State or foreign country)

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Bertie Mc Kenzie

(b) Address: 2306 Indiana

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn Cem

18. (a) Signature of funeral director: Mellody-McKilley Sylar

(b) Address: K.C. Mo

19. (a) 6-1-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 year 1945 hour 1:50 minute A M.

21. I hereby certify that I attended the deceased from May 25 1945, 19, to May 31, 19 45, that I last saw him alive on May 30, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Miocardial failure — Duration

Due to: Prostatic hypertrophy with retention

Due to: Crippled in accident in 1936 Made helpless to go down stairs

Other conditions (Include pregnancy within 3 months of death): 137a

Major findings: Of operations: Enlarged prostate and the urethral prostatic channel closed with hypertrophied tissue

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:

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: [illegible] (M.D. or other)

Address: 918 Oak St., Kansas City Date signed 6-1-45

(Licensed Embalmer's Statement on Reverse Side)

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 Russell N France

Licensed Embalmer No. 4255

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.