

FILED NOV 26 1945
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Registration District No. _____ Primary Registration District No. 1002

Registrar's No. 4682

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 No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos. 14 days
(Specify whether _____)

In this community 60 years
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. 3438 Michigan
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Shumard

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 Widower

6. (b) Name of husband or wife Estella Shumard 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 17th, 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	8 5	4	25	_____ hr. _____ min.

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

10. Usual occupation Retired Salesman

11. Industry or business _____

MOTHER FATHER { 12. Name Warren Shumard

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

14. Maiden name Lida Holmes

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

16. (a) Informant Mrs Louise Shubert

(b) Address 3438 Michigan, K.C. Mo.

17. (a) Burial (b) Date thereof 11/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Melody-McGilley-Bylar

(b) Address Kansas City Mo.

19. (a) 11-13-45 (b) Khaldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12
year 1945 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from August 28, 1945, to Nov. 12, 1945;
that I last saw him alive on Nov. 12, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy None

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Clark W. Leely
Address Med. Dir. Gen'l Hosp. Date signed 11-13-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.