

FILED JAN 24 1946
Registration District No. _____

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

(d) Length of stay: In hospital or institution 11 days
(Specify whether _____)

In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 547 1/2 Main 8
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME James Grey

3. (b) If veteran, name war none

3. (c) Social Security No. Do not know

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28
year 1945 hour 1 minute A. M.

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 Jan 16 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 17 1945 to Dec. 28 1945
that I last saw h. im alive on Dec. 28 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 11 Days 13 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebrovascular accident

Due to _____

Due to _____

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

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

Major findings: 8/30

11. Industry or business _____

12. Name Paul Gray

13. Birthplace Scotland 4
(City, town, or county) (State or foreign country)

14. Maiden name Helen Spence

15. Birthplace Scotland 4
(City, town, or county) (State or foreign country)

Of autopsy None

22. If death was due to external causes, fill in the following:

16. (b) Informant Parental Hospital

(b) Address K C Mo

17. (a) Removal (b) Date thereof Dec 31 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvary K C Mo

(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? _____

18. (a) Signature of funeral director Parental Hosp

(b) Address _____

19. (a) 12-29-45 (b) Estelaine Holmes
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Clark A. Seibert
Address Med. Dir. Gen'l Hosp. Date signed 12-28-45

100291
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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

Dr. K...

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 *Fredrick Walter*
Licensed Embalmer No. *2744*
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.