

No. 2
5-43
17-39
X36671

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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:
Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution less than 24 hrs.
(Specify whether
In this community 40 years
years, months or days)

3. (a) PRINT FULL NAME FRANK L. KELSEY

3. (b) If veteran, name war. no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed

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

7. Birth date of deceased September 26 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 2 05 hr. min.

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

10. Usual occupation retired railroad engineer

11. Industry or business

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant H. E. Evans

(b) Address Hickman Mills Mo.

17. (a) burial (b) Date thereof 12-3-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director BENTLEY MORTUARY

(b) Address 5811 Troost

19. (a) 12-3-46 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Hickman Mills
(If outside city or town limits, write "RURAL") 0
(d) Street No. Route #1
(If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 1
year 1946 hour 8:00 minute 2 M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that I last saw him _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Skull
Due to lacerating force months & Tongue
Due to auto + pedestrian

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 1700-8
21
Of autopsy no
History + Inspection

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 123
(b) Date of occurrence 11-30-16
(c) Where did injury occur? Jackson Miss
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place

While at work? no (Specify type of place) (e) Means of injury auto + train

23. Signature Samuel W. ... (M. D. or other) 0
Address 1424 ... Date signed 12-7-46

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

Guy Buffington

Licensed Embalmer No. *2756*

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.