

No. 2  
-12-45  
5-17-39  
I X47070

FILED MAR 25 1947  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1164

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: OSTEOPATHIC HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10-DAYS  
In this community 2 1/2 YEARS (Specify whether years, months or days)

3. (a) PRINT FULL NAME DR. JAMES EDGAR HYMER

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 SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JUNE 30 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 8 12 hr. min.

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

10. Usual occupation M.D. RETIRED

11. Industry or business \_\_\_\_\_

12. Name JAMES M. HYMER

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

14. Maiden name MARCEY ROGERS

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

16. (a) Informant Herbert C. Hymer  
(b) Address 3421 Tracy, One RC

17. (a) Burial (b) Date thereof MAR-14-1947  
(Burial, cremation, or removal) (City or town) (County) (State) (Year)

(c) Place: burial or cremation Franklin Liberty, Mo

18. (a) Signature of funeral director D. H. Newcomer's Sons  
(b) Address 1401 BRUSH CREEK BLYD.

19. (a) 3-14-47 Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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. 3606 WILSON 8  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 12 TH  
year 1947 hour 7 minute 50 A.M.

21. I hereby certify that I attended the deceased from AUG. 7,  
1946, to MARCH 12, 1947;  
that I last saw him alive on MARCH 11 (10:00 p.m.), 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death HYPOSTATIC PNEUMONIA Duration \_\_\_\_\_

Due to APOPLEXY

Due to HYPERTENSION

Other conditions OBSTINATION (paralysis from shock of hemorrhage)  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 830

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

22. If death was due to external causes, fill in the following: NO.

(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) (e) Means of injury 2

23. Signature Warren M. Jones (M. D. or other) D.O.

Address 3401 East 31 St Date signed 3-12-47

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

MOTHER, FATHER

3400 East 39th St.  
9:30-12

**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 Emile M. Calhoun  
Licensed Embalmer No. 3506  
P. O. Address KC 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.**