

No. 2  
1/47  
17-39

National Office of Vital Statistics  
FILED AUG 26 1947  
Registration District No. 149

Primary Registration District No. 1002

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

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 Lot 509 Main St 2  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson 49

(c) City or town Kansas City 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 514 1/2 Main St 8  
(If rural, give location)

(e) Citizen of foreign country? unknown (Yes or No) 0  
If yes, name country

3. (a) PRINT FULL NAME Don C Flacy

3. (b) If veteran, name war none

3. (c) Social Security No. 565-01-2573

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced unknown

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased March 18 1906  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

41 4 21 br. min.

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

10. Usual occupation Labor

11. Industry or business

12. Name Useless Flacy

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

14. Maiden name Do not know

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

16. (a) Informant Carrner office

(b) Address 12 C no

17. (a) cremial (b) Date thereof Aug 10 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt bury no

18. (a) Signature of funeral director Pameter Doss

(b) Address 12 C no

19. (a) 8-10-47 (b) Heraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9  
year 1947 hour 3 minute 20 P. M.

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

Immediate cause of death Coronary Insufficiency

Due to as above

Due to.....

Other conditions..... (include pregnancy within 3 months of death)

Major findings: Of operations 77.8

Of autopsy no  
Histology + Imprints

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 Jane [unclear] (M. D. or other) Carrner

Address 1424 N. M. Date signed 8-10-47

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

MOTHER FATHER

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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 \_\_\_\_\_

*Dwight L. Kelsey*

Licensed Embalmer No. \_\_\_\_\_

*4225*

P. O. Address \_\_\_\_\_

*Indep. 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.