

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4520

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 Luther Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Days
In this community 10 years
(Specify whether 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. 4628 Broadway
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1947 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from 10/16 to 10/27, 1947
that I last saw him alive on 10/27, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
Coronary occlusion
Due to Acute Myocardial Infarction
Due to Coronary occlusion

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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?

(Specify type of place)
While at work Physician's Office (e) Means of injury 0

23. Signature Rephael (M. D. or other)
Address 221 Plaza Medical Bldg

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, married
6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased 19-18-88
(Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 28
If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business William & Rogest

12. Name Georgia

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

14. Maiden name Carrie L. Williams

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

16. (a) Informant Frank R. Campbell

(b) Address 4628 Broadway

17. (a) Removal (b) Date thereof 10/29/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atlanta Ga.

18. (a) Signature of funeral director Arthur M. Oure

(b) Address Kansas City, Mo

19. (a) 10-29-47 (b) Gertrude Holmes
(Date received local registrar) (Registrar's signature)

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

Dr. Crawford
315-244-1111
Pembroke

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

J. Clair Sheppard

Licensed Embalmer No. *4/179*

P. O. Address. *15 E. ...*

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.