

FILED APR 24 1948

Registration District No.

Primary Registration District No.

149

1002

1686

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: Research Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Weeks
In this community 38 Yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 6160 Cherry
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mr. Joseph Harry Mack

(b) If veteran, name war No (c) Social Security No. 186-03-1178

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Dec. 26 1886
(Month) (Day) (Year)

8. AGE: Years 61 Months 3 Days 19
If less than one day hr. min.

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

10. Usual occupation Salesman

11. Industry or business K.C. Auto Supply

MOTHER FATHER
12. Name Wm. Mack
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Arvilla Avery
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joseph H. Mack

(b) Address 6160 Cherry

17. (a) Burial (b) Date thereof 4-17-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Stine & McClure

(b) Address Kansas City, Mo.

19. (a) 4-17-48 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
year 1948 hour 8 minute 55 A.M.

21. I hereby certify that I attended the deceased from January 14, 1947, to April 15, 1948, that I last saw him alive on April 15, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Generalized arteriosclerosis
vascular disease
Acute renal and hepatic insufficiency with systemic hypertension heart disease
Due to with congestive failure

Duration
16 months
6 months
2 week
PHYSICIAN
Underline the cause to which death should be charged statistically.

Other conditions Thrombosis of abdominal aorta
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy As above - 932

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?
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Graham Acker (M. D. or other) M.D.
Address 12700 Professional Bldg. Date signed 4-15-48

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

18
3
8

48
3
8
0

Kansas City Mo

By *Robert H. Reed*
10/15

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 *Robert H. Reed*

Licensed Embalmer No. *3145*

P. O. Address *H. C. Ho*

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.