

S. No. 300
M-10-47
ev. 5-17-39
I 3906

FILED JUN 1 1948
Registration District No. **949**

Primary Registration District No. **1002**

WRITE PLAINLY—USE 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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days) unknown

3: (a) PRINT FULL NAME JOHN MAYNES

3. (b) If veteran, name war Do not know 3. (c) Social Security No. Do not know

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

6. (b) Name of husband or wife Do not know 6. (c) Age of husband or wife if alive Do not know years

7. Birth date of deceased July 23 1873
(Month) (Day) (Year)

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

74 9 24 hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name Do not know 9

13. Birthplace Do not know (City, town, or county) (State or foreign country)

14. Maiden name Do not know

15. Birthplace Do not know (City, town, or county) (State or foreign country)

16. (a) Informant General Hospital

(b) Address 12 CMO

17. (a) Removal (b) Date thereof May 19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary L.C.H.

18. (a) Signature of funeral director P. Cassantino

(b) Address 12 CMO

19. (a) 5-19-48 (b) 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. 558 Main **X**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17th
year 1948 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from May 11, 1948 to May 17, 1948;
that I last saw him alive on May 17, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Miliary Tuberculosis Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: 22-01

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? **0**

While at work? (Specify type of place) (c) Means of injury.....

23. Signature W. W. Hart (M. D. or other) **248**
Address Med. Dir. General Hospital Date signed 5-18-48

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 Francis Walter

Licensed Embalmer No. 2744

P. O. Address 15 Cmo

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.