

No. 2
-5-43
5-17-39
I X36671

FILED NOV 6 1948
Registration District No. 149

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:
709 Washington 1
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community Do not know
years, months or days

3. (a) PRINT FULL NAME Peter Hay's

3. (b) If veteran, name war Do not know

3. (c) Social Security number 500-10-5048

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 10-11-82
(Month) (Day) (Year)

8. AGE: Years 65 Months 66 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation NOV P

11. Industry or business _____

MOTHER FATHER

12. Name Do not know

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

14. Maiden name _____

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

16. (a) Informant CORNER OFFICE

(b) Address 15 C MO

17. (a) SCHOOL (b) Date thereof Oct 21 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation College of Osteopathy & Surgery

18. (a) Signature of funeral director Passaric, Triopres

(b) Address 15 C MO

19. (a) 10-20-48 (b) Shalline Holme
(Date received local registrar) (Registrar's signature)

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. 709 Washington
(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 18
year 1948 hour 12 minute 05 P M.

21. I hereby certify that I attended the deceased from born 19____, to _____ 19____;

that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction

Due to arteriosclerosis

Due to _____

Other conditions 930
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no
History & Inspection

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? yes

(e) Means of injury _____ (Specify type of place)

While at work? James C. Walker

23. Signature James C. Walker (M. D. or other) _____
Address 1424 W. My Date signed 10-20-48

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 *12 Cmv*

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.