

STANDARD CERTIFICATE OF DEATH

FILED OCT 20 1954

State File No. 4574

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY JACKSON	
b. CITY (If inside corporate limits, write RURAL and give township) KANSAS CITY		c. LENGTH OF STAY (in this place) 42 MOYRS	d. IS RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. CITY OR TOWN KANSAS CITY		13. STREET ADDRESS (If rural, give location) 6433 Pennsylvania	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hosp.		14. DATE OF DEATH (Month) (Day) (Year) 9-29-54	

3. NAME OF DECEASED (Type or Print) a. (First) Raymond b. (Middle) H. c. (Last) James		4. DATE OF DEATH (Month) (Day) (Year) 9-29-54	
5. SEX M	6. COLOR OF RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 6-9-87
9. AGE (In years last birthday) 67	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-DIV. MANGER	10b. KIND OF BUSINESS OR INDUSTRY SUNKIST, INC.	11. BIRTHPLACE (City and State or Foreign Country) WILMINGTON, OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH JAMES	

13b. MOTHER'S MAIDEN NAME ESPER ANN McFADDEN		14. NAME OF HUSBAND OR WIFE Marley C. JAMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 486-09-3492	
17. INFORMANT'S SIGNATURE OR NAME William J. James Dallas, Texas			

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Hypertrophy terminal Bronchopneumonia		331X	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		DUE TO (b) _____	
				DUE TO (c) _____	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept 18, 1949, to Sept 29, 1954, that I last saw the deceased alive on Sept 29, 1954, and that death occurred at 3:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE Jack W. Wolf (Degree or title) A.D.		23b. ADDRESS 415 E. 63 ST. Kansas City, Mo.		23c. DATE SIGNED 9/29/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9-30-1954		24c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEM.		24d. LOCATION (City, town, or county) (State) KANSAS CITY Mo	
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DATE REC'D BY LOCAL REG. 9-30-54		REGISTRAR'S SIGNATURE newman		25. FUNERAL DIRECTOR'S SIGNATURE D. W. Newcomer		ADDRESS 1051 Brown Street Kan. City, Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Robert E. Kessner*

Licensed Embalmer No. *489*

P. O. Address *K. C. Moore*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.