

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38523

1939 DEC 11 1939
Registration District No. 999

Primary Registration District No. 1002

Registrar's No. 4287

1. PLACE OF DEATH:

(a) County Jackson 2
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1609 E. 9th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
45 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Samuel M. Carmean 6553. (b) If veteran, name war No 3. (c) Social Security No. no4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife. Mrs. Anna M. Carmean 6. (c) Age of husband or wife if alive 76 years7. Birth date of deceased. June 19, 1866
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
73 4 20 hr. min.9. Birthplace Ohio
(City, town, or county) (State or foreign country)10. Usual occupation Lawyer11. Industry or business 112. Name James H. Carmean 113. Birthplace Ohio
(City, town, or county) (State or foreign country)14. Maiden name Mary Leffingwell15. Birthplace Ohio
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Anna M. Carmean(b) Address 1609 E. 9th St., K.C., Mo.17. (a) Burial (b) Date thereof 11-11-1939
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Washington18. (a) Signature of funeral director Freeman Mortuary(b) Address 104 W. 42nd St., K.C., Mo.19. (a) 11-10-39 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1609 E. 9th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9,
year 1939 hour _____ minute 11:10 a.m.

21. I hereby certify that I attended the deceased from
Oct 19th, 1939, to Nov 9th, 1939;
that I last saw him alive on Nov 9th, 1939;
and that death occurred on the date and hour stated above.
Immediate cause of death Uremic poison Duration
about four days.

Due to Hypertrophic and cystic kidney in right and atrophy on left.
Due to _____

Other conditions Chronic cystitis, arteriosclerosis
(include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy Rt. Hypertrophic and cystic kidney, and left atrophy and fibrosis

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? 3 (Specify type of place) (e) Means of injury _____23. Signature Dr. F. A. D. Melly (M. D. or other) Dr.
Address 2748 Charlotte St. Date signed 11/9/39

PHYSICIAN

Underline the cause to which death should be charged statistically.

3
2
1

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 Charles W. Charles

....., Registered Apprentice No.
working under my personal supervision.

Signed Charles W. Charles

.....
Licensed Embalmer No. 3473

P. O. Address K. C. W. O.

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, above space should be left blank.