

DEC 22 1939

State File No. _____

Registration District No. _____

Primary Registration District No. 5-5-15

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Raytown
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 20 years, months or days

3. (a) PRINT FULL NAME

Thomas Stewart Minor

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Marguerite Minor

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

7. Birth date of deceased April 14 1909
(Month) (Day) (Year)

8. AGE: Years 30 Months 7 Days 6
If less than one day hr. _____ min. _____

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

10. Usual occupation Emp Chevrolet Factory

11. Industry or business Auto

12. Name Carl Minor

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

14. Maiden name Kate Gibson

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

16. (a) Informant's own signature Carl Minor
(b) Address 215 Summit R.R. 3, 3rd

17. (a) Burial (b) Date thereof 11/22/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warrensburg Mo.
18. (a) Signature of funeral director J. B. Langford
(b) Address 215 Summit R.R. 3

19. (a) 11-22-39 (b) W. B. Gibson
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town 4141 Raytown Rd.
(If outside city or town limits, write "RURAL")
(d) Street No. Jackson Co. Kansas City Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20
year 1939 hour 9.30 minute _____ M.

21. I hereby certify that I attended the deceased from Aug
_____, 1939, to Nov 20, 1939;
that I last saw him alive on Nov 19, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Uraemia Duration 10 hrs

Due to Acute Strep throat

Due to Acute + Chronic Glomerulonephritis

Other conditions Diarrhea & emesis

Major findings: Of operations _____

Of autopsy 121

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? _____

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

23. Signature J. Hombay (M. D. or other) _____
Address Independence Mo Date signed 11-21-39

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

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 me

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

Signed W.B. Langford

Licensed Embalmer No. 3933

P. O. Address Leis Summit

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39870

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 400
(b) Township Praine Primary Registration District No. 53-53B Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Thomas Stewart Minor
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marquette Minor

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 7 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 1-12-1940 Sand L. Jones Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 20 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) L. G. Combs, M. D.

(Address) Independence Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

