

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42194

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4603

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No.  
(Specify whether

In this community Unknown  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Missouri.  
(If outside city or town limits, write "RURAL")

(d) Street No. 805 Penn. Avenue, K.C., Mo.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Lloyd Best 230

3. (b) If veteran,  name war World War

3. (c) Social Security No. 486-01-5945

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Carrie Best

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased August 17 1896  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1st, 1939  
year 1939 hour \_\_\_\_\_ minute 7: P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>43</u>	<u>3</u>	<u>14</u>	_____ hr. _____ min.

9. Birthplace Snodaway Co., Mo. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Truck Driver- Williams Roofing Co.

Immediate cause of death Myocardial Infarction

Due to Coronary Artery

Due to Medial Nerve, Artery

Other conditions None  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name George Best

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

14. Maiden name Minnie Stotts

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

16. (a) Informant's own signature Mrs. Carrie Best

(b) Address 805 Penn.

17. (a) Burial (b) Date thereof Dec. 4 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill, Cem. K.C., Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn Avenue, K.C., Mo.

19. (a) Dec. 4, 1939 (b) Missouri  
(Date received local registrar) (Registrar's signature)

Major findings: None

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
\_\_\_\_\_ (Specify type of place)

While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. S. ... (M. D. or other) \_\_\_\_\_

Address ... Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

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.

**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. 244  
working under my personal supervision.

Signed Thomas A. Redmon

Licensed Embalmer No. 2737

P. O. Address R.C. 2119

**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

42194  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 344  
(b) Township \_\_\_\_\_ Primary Registration District No. 1002  
(c) City R.C. (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

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
Lloyd Best

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 1 1934

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
43 3 14

The principal cause of death and related causes of importance were as follows:

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 \_\_\_\_\_

Myocardial infarction  
Laceration of pericardium  
Medial necrosis of aorta  
Rupture of aorta

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

Other contributory causes of importance: \_\_\_\_\_

13. NAME

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

15. MAIDEN NAME

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

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

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

20. FILED Dec 4 1934 M. M. Brown Local Registrar.

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

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease of injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Russell Kerr, M. D.

(Address) R.C. Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIAN'S SIGNATURE STATE CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

