DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5478

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 703

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: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-24-40-2-10-40 (Specify whether

In this community 25 years (years, months or days)

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.: 1310 Highland Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Bud Ross

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: Negro

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

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: 3 years

7. Birth date of deceased: 8 (Month) 3 (Day) 1891 (Year)

8. AGE: Years 48 | Months 6 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace: Louisiana (City, town, or county) (State or foreign country)

10. Usual occupation: Barber

11. Industry or business:

FATHER
12. Name: Henry Ross
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Bettie Williams
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Record Clerk

(b) Address: General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/40 (Month) (Day) (Year)

(c) Place: burial or cremation: Highland Cemetery

18. (a) Signature of funeral director: Hutkins Bros

(b) Address: 1729 Lydia

19. (a) Feb 16 40 (Date received local registrar) (b) M M Weaver (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 10 year 40 hour 10 minute 25 A. M.

21. I hereby certify that I attended the deceased from 1-24- 19 40, to 2-10- 19 40 that I last saw him alive on 2-10- 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertensive Type of Heart Disease.	
Due to: Hypertension.	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: O O Turner (M. D. or other)

Address: General Hospital #2 Date signed 2-12-40

(Licensed Embalmer's Statement on Reverse Side)

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....,

working under my personal supervision.

Signed Isaac Jerome Manlove

Licensed Embalmer No. 3994

P. O. Address 1120 E 23rd St

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.