DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5484

Primary Registration District No. 1002

Registrar's No. 709

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 2-13-40-2-13-40 (Specify whether years, months or days)

In this community 15 years

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. 1330 Vine St.
(If rural, give location)

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

3. (a) PRINT FULL NAME: Andrew Claiborne

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: ____ years

7. Birth date of deceased: 9 (Month) 21 (Day) 1888 (Year)

8. AGE: Years 51 Months 4 Days 23 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Danrige Claiborne
13. Birthplace: (City, town, or county) Ark. (State or foreign country)

MOTHER
14. Maiden name: Catherine Cobb
15. Birthplace: (City, town, or county) Ark. (State or foreign country)

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

(b) Address: General Hospital #2

17. (a) BLUERIDGE LATT (Burial, cremation, or removal) (b) Date thereof: 2-17-40 (Month) (Day) (Year)

(c) Place: burial or cremation: KANSAS CITY, MISSOURI

18. (a) Signature of funeral director: E. Sterling Bills

(b) Address: 1811 E. 12th K. C. Missouri

19. (a) 2-17-40 (Date received local registrar) (b) M. M. Crowe, asst (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 13 year 40 hour 2 minute 55 P. M.

21. I hereby certify that I attended the deceased from 2-13- 1940 to 2-13- 1940 that I last saw him alive on 2-13- 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal Obstruction (P.O.)	
Due to:	
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: A. C. Prime (M. D. or other)

Address: General Hospital #2 Date signed 2-14-

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 — 1 X19811

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 E. Sterling Bills

Licensed Embalmer No. 3178

P. O. Address 1816 12th KC M

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.

B-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 548-4X

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 709-

1. PLACE OF DEATH

(a) County: Jackson

(b) City or town: K.C. (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 years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____ (If outside city or town limits write "RURAL")

(d) Street No. ____ (If rural, give location)

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

3. (a) PRINT FULL NAME: Andrew Claiborne

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex ____ 5. Color or race ____ 6. (a) Single, widowed, married, divorced ____

6. (b) Name of husband or wife ____ 6. (c) Age of husband, or wife, if alive ____ years

7. Birth date of deceased ____ (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
51			hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) (State or foreign country)

16. (a) Informant ____

(b) Address ____

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

(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____

(b) Address ____

19. (a) 7/17/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 13 day 40 year ____ hour ____ minute ____ M.

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

Immediate cause of death: Intestinal Obs. P.O.

Due to: Intestinal adhesions operated on Feb. 13, 1940

Due to: ____

Other conditions (Include pregnancy within 3 months of death): 127 B

Major findings: Of operations ____

Of autopsy ____

Duration

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) (e) Means of injury ____

23. Signature P. C. Turner (M. D. or other)

Address ____ Date signed ____

SUPPLEMENTARY

S-5484