

5683

908

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

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1002

FILED MAR 11 1940

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: K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution two days (Specify whether
 In this community unknown
 years, months or days)

3. (a) PRINT FULL NAME 260 BASHER, (Given name unknown)3. (b) If veteran, name war No record 3. (c) Social Security No. _____4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced No record6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased No record
(Month) (Day) (Year)8. AGE: Years No record Months ✓ Days _____ If less than one day
hr. _____ min.9. Birthplace No record
(City, town, or county) (State or foreign country)10. Usual occupation No record11. Industry or business No record12. Name No record13. Birthplace No record
(City, town, or county) (State or foreign country)14. Maiden name No record15. Birthplace No record
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Record clerk(b) Address K.C. Gen. Hosp.17. (a) Removal (b) Date thereof 2-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Charles of St. Joseph18. (a) Signature of funeral director Wm. R. Schmitz(b) Address St. Charles of St. Joseph19. (a) Feb. 28, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 26th
year 1940 hour 6:00 P.M. minute _____ M.21. I hereby certify that I attended the deceased from Jan. 24th
1940, to Jan. 26th, 19 40that I last saw him alive on Jan. 26th, 19 40;
and that death occurred on the date and hour stated above.Immediate cause of death S.
Lobar pneumonia

Duration

Due to _____

Due to _____

Other conditions Senile dementia
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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)
 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 G. De Maria M.D. (M. D. or other)
Supt. K.C. Gen. Hospital K.C. Mo. Date signed 1-27-40
Address _____

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

Wm A. Schuyler

Licensed Embalmer No: *3089*

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

5683

Registration District No.

399

Primary Registration District No.

1002

Registrar's No.

908

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
In this community years, months or days)

3. (a) PRINCE FULL Barker Given name ink.

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. ink

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

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

8. AGE: Years Months Days If less than one day
approximately 70 years of age
hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

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

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (c) Signature of funeral director

(b) Address

19. (a) 1/28/40 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County W

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 26
year hour minute M.

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

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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. F. Demas (M. D. or other)

Address Remington Date signed K.C.

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

S-5683