

APR 12 1940
Registration District No. 399

Primary Registration District No. 1002

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 2-23-40-3-7-40
(Specify whether years, months or days) 39 years

3. (a) PRINT FULL NAME George Little 340

3. (b) If veteran, No name war. 3. (c) Social Security No. 486-07-9158

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

6. (b) Name of husband or wife Willa Mae Little 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12 21 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 2 Days 15 If less than one day hr. _____ min.

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

10. Usual occupation none Truck Driver

11. Industry or business _____

12. Name Unknown George Little

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

14. Maiden name Harriet Jenkins

15. Birthplace Uniontown Missouri
(City, town, or county) (State or foreign country)

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

(b) Address General Hospital #2

17. (a) burial (b) Date thereof 3/11/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Jenkins Bros.

(b) Address 1729 India

19. (a) Mch 9, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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. 1519 Harrison St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 7
year 40 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from 2-23- 19 40 to 3-7- 19 40

that I last saw him alive on 3-7- 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Moderately Advanced Pulmonary Tuberculosis.

Due to 23

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 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? _____

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

23. Signature W. A. Depue (M. D. or other) _____

Address General Hospital #2 Date signed 3-8-

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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 R. M. Adams

Licensed Embalmer No. 4116

P. O. Address 1729 Lydia

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. 965-6
Registrar's No. 1090

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town J.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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME George Little
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race negro 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased 12 21 1905
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>2</u>	<u>15</u>	_____ 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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Mary 1940 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION
20. DATE OF DEATH Month 3 day 7
year 1940 hour _____ minute _____ 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.

Immediate cause of death _____	Duration _____
Due to _____	
Due to _____	
Other conditions _____ (Include pregnancy within 3 months of death)	
Major findings: Of operations _____	PHYSICIAN _____
Of autopsy _____	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) _____ (e) Means of injury _____

23. Signature P. C. Insner (M. D. or other) _____

Address San 1st St. Date signed _____

1940
S-9656