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

State File No.

Registrar's No.

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:
1016 Troost Ave.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 2
 In this community 60 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Amanda Russell 240
 (b) If veteran, name war Aminda Russell
 (c) Social Security No. 70

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced, widow
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 27 years
 7. Birth date of deceased. 12 (Month) 27 (Day) 1862 (Year)

8. AGE: Years 79 Months 2 Days 28 If less than one day hr. min.

9. Birthplace Clay Co - Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER
 { 12. Name Kenouch Russell
 { 13. Birthplace unknown
 { 14. Maiden name Grace Ann Thornton
 { 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm. B. Owens

(b) Address 1016 Troost Ave

17. (a) Burial (b) Date thereof 3-28-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director W. B. Moore

(b) Address 1820 E. 18th St

19. (a) Mch 27, 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. 1016 Troost Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3rd day 26
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Mar 14
1940 to Mar 26, 1940
 that I last saw her alive on Mar 26, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Paraplegia
 Due to Cerebral Hemorrhage

Due to 2 8 1/2

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 70

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 70

(b) Date of occurrence 70

(c) Where did injury occur? 70
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work 3 (Specify type of place) (e) Means of injury _____

23. Signatur W. B. Moore (M. D. or other) 70
 Address 1705 E 12 Date signed Mar 26

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

AB Moore

Registered Apprentice No.

working under my personal supervision.

Signed

AB Moore

Licensed Embalmer No.

12410

P. O. Address

1820 E 18th 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.