DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1002

13739
State File No.

Registration District No. [illegible] 399

Primary Registration District No.

1511
Registrar's No.

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 2-27-40-2-29-40
(Specify whether
In this community 19 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. 1418½ Woodland Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Andrew Dawson 250

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 Married

6. (b) Name of husband or wife Martha Dawson

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

7. Birth date of deceased Oct. 15, 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 4 Days 14 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business ?

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

MOTHER
14. Maiden name Unknown
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) Blue Ridge Cem. (Burial, cremation, or removal) (b) Date thereof April 8, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation K. C. Mo.

18. (a) Signature of funeral director E. Sterling Bills
(b) Address 1811 E. 42 Terr.

19. (a) April 8, 1940 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 29 year 40 hour 1 minute 20 P. M.

21. I hereby certify that I attended the deceased from 2-27- 40, to 2-29- 40, that I last saw h. 1m alive on 2-29- 40 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Decompensation with Circulatory Failure	
Due to: Oral Sepsis 95 B	
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 J. A. Turner (M. D. or other)
Address General Hospital #2 Date signed 3-1-40

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.

(Licensed Embalmer's Statement on Reverse Side)

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 Bell

Licensed Embalmer No. 3178

P. O. Address 1811 6th St, N.W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.