

14007

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

MAY 15 1940

399

Primary Registration District No. 1002

Registrar's No. 1719

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 3-31-40-3-31-40
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Infant Walker 426
3. (b) If veteran, name war _____ 3. (c) Social Security 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 3 31 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 5 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
12. Name Leon Walker
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Thelma
15. Birthplace Mo.
(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 4-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Municipal Cem. Leeds, Mo.

18. (a) Signature of funeral director W.A. Lehmeyer
(b) Address K.C. Gen. Hospital No. 2
4-22-1940
19. (a) _____ (b) M.M. Brown
(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. 2300 Vine 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 31
year 40 hour 10 minute 55 A. M.

21. I hereby certify that I attended the deceased from 3-31- 1940 to 3-31- 1940
that I last saw him alive on 3-31- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Internal Hemorrhage.

Due to _____

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 [Signature] (M.D. or other) _____
Address General Hospital #2 Date signed _____

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 _____

Licensed Embalmer No. _____

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.