

14079

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 15 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1791

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City ¹

(c) Name of hospital or institution: Kansas City Tuberculosis Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 17 days
(Specify whether _____)

In this community 13 years
years, months or days)

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. 437 W. 14th
(If rural, give location)

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

3. (a) PRINT FULL NAME Lee, Delbert ~~Bob~~

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1940 hour 1 minute 32 A.M.

21. I hereby certify that I attended the deceased from April 12, 1940
19____, to April 29, 1940;

that I last saw him alive on April 29, 1940
and that death occurred on the date and hour stated above.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Margie

6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased September 16, 1908 ¹⁹⁴⁰
(Month) (Day) (Year)

Immediate cause of death Pulmonary tuberculosis

Due to _____ TB

Due to _____

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

Duration
Oct. 1939
to Apr. 1940

8. AGE: Years 30 Months 7 Days 14
If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER {

12. Name Lee, Sam G

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

14. Maiden name Lee, Cora ?

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature K.C.T.B. Hospital

(b) Address _____

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? _____

17. (a) removal (b) Date thereof April 29 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Princeton Mo

18. (a) Signature of funeral director Mrs. C. I. Floate

(b) Address K.C. Mo

While at work? _____ (Specify type of place)

(e) Means of injury !

23. Signature C. H. Hays, M.D. (M. D. or other)

Address C. H. Hays, M.D. Hospital Date signed _____

19. (a) April 28, 1940 M. M. Brown
(Date received local registrar) (Registrar's signature)

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.