S. No. 2
-11-10-39
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PI X21492

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

FILED JUN 17 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17450

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1977

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: 1509 Park
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)
In this community 20 years

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. 1509 Park
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Charley Versa
3. (b) If veteran, name war No
Charley Versa
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 Lucy Versa
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Oct (Month) Unk (Day) 1882 (Year)

8. AGE: Years 57 Months 7 Days Unk If less than one day ____ hr. ____ min.

9. Birthplace Keane (City, town, or county) Texas (State or foreign country)
10. Usual occupation Minister
11. Industry or business
MOTHER FATHER
12. Name Bob Versa
13. Birthplace not known (City, town, or county) (State or foreign country)
14. Maiden name not known
15. Birthplace not known (City, town, or county) (State or foreign country)
16. (a) Informant Lucy Versa
(b) Address 1509 Park
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Keane Tex.
18. (a) Signature of funeral director Kenny Funeral Home
(b) Address 1905 E 14 St Kansas City Mo
19. (a) May 12, 1940 (Date received local registrar) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1940 hour 3 minute 30 A.M.
21. I hereby certify that I attended the deceased from May 5 1940, 19__ to May 7 1940, 19__ that I last saw h~~im~~ alive on May 6 1940 and that death occurred on the date and ~~hour~~ stated above.

Immediate cause of death	Duration
Acute Myocarditis	3 days
Due to: Parenchymatous Nephritis, Chronic	
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 R B Garrett (M. D. or other)
Address 2200½ E 15th Date signed May 8 1940

(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 [illegible]

Licensed Embalmer No. 3388

P. O. Address K. E. [illegible]

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.