G. No. 2
-11-10-39
5-17-39
P I X21492

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

FILED JUL 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20692

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2309

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: St Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1day (Specify whether
In this community 60 Yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Raytown
(If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

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

3. (a) PRINT FULL NAME Robert Dehoney -- 500

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race W

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

6. (b) Name of husband or wife Victoria Dehoney

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

7. Birth date of deceased Aug. 1 1865 (Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 2 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name Leander Dehoney
13. Birthplace ..... (City, town, or county) Ky. (State or foreign country)

MOTHER
14. Maiden name Sarah Chism
15. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

16. (a) Informant R.C.Dehoney
(b) Address Raytown Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Brookings

18. (a) Signature of funeral director Mrs C.L.Forster
(b) Address 918 Brooklyn Kansas City

19. (a) June 5, 1940 (Date received local registrar) (b) M.M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 3-40
year ..... hour ..... minute 4:30 P M.

21. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 ..... ; that I last saw ..... alive on ..... 19 ..... ; and that death occurred on the date and hour stated above.

Immediate cause of death Crushing Injury Chest

Due to Fract Ribs & Lac Lungs

Due to Fracture of the Skull

Other conditions Auto Accident (in Car)
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Alm

Duration

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) Accident
(b) Date of occurrence 6-3-40
(c) Where did injury occur? Raytown Jackson Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hit by another car while in our car (Specify type of place)
While at work? (e) Means of injury Accident

23. Signature Russell Wyan (M. D. or other)
Address Kan Date signed

(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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address K. C. Mo

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.