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A21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20767

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2384

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. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Days (Specify whether
In this community Non-Resident
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Newton

(c) City or town Seneca
(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 John Erricks 620

3. (b) If veteran, name war No

3. (c) Social Security No. 702-12-3446

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Frances Errick

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

7. Birth date of deceased April (Month) 23 (Day) 1897 (Year)

8. AGE: Years 63 Months 1 Days 17 If less than one day hr. min.

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

10. Usual occupation Flagman K.C.S. R.R.

11. Industry or business Unknown

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

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

16. (a) Informant Richard Anderson
(b) Address Seneca Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 13, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Sagney Mo.

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

19. (a) June 11, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11
year 1940 hour 4 minute A M.

21. I hereby certify that I attended the deceased from 5-27, 1940 to 6-11, 1940
that I last saw him alive on 6-10-, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Extravasation of urine	
Due to Senile Hypertrophy of Prostate	
Due to Chronic Pyelo cystitis 137	
Other conditions arteriosclerosis (Include pregnancy within 3 months of death) Enlarged Prostate	
Major findings: Of operations Cystitis Cystotomy 6-4-40	
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 [signature] (M. D. or other)
Address 800 Argyle Date signed 6-11-40

(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 Darryl 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.

S. No. 2B
M—2-21-40
1 X22659

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

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20767

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2384

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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 John Erricks

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife, if alive 1877 years

7. Birth date of deceased Apr - 13 - 1897
(Month) (Day) (Year)

8. AGE: Years 63 Months 1 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) 6/11/40 (Date received local registrar) (b) M. M. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11
year 1940 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
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 W. P. Miller (M. D. or other)
Address 800 Argyle Date signed
K.C. Mo