

S. No. 2
-11-10-39
5-17-39
I X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20769**
Registrar's No. **2386**

Registration District No. **399** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **K.C. General Hospital No. 1**
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution **8 days**
In this community **4 1/2 yrs**
years, months or days

8. (a) PRINT FULL NAME **George W. Helm** **450**
8. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Mary** 6. (c) Age of husband or wife if alive **23** years
7. Birth date of deceased **Jan 23 1867**
(Month) (Day) (Year)

8. AGE: Years **78** Months **4** Days **15** If less than one day hr. min.

9. Birthplace **X Africa** **MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Conductor**

11. Industry or business **Street Car Co. A**

12. Name **Miriam Helm**
13. Birthplace **Kent** **1864**
(City, town, or county) (State or foreign country)
14. Maiden name **Kent**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **E. M. Helm**
(b) Address **3410 Monroe, K.C.**

17. (a) **Burial** (b) Date thereof **6-10-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park K.C.**
18. (a) Signature of funeral director **P. A. Fulton**
(b) Address **Kansas City, Mo**
19. (a) **June 11, 1940** (b) **M. M. Browe**
(Date received local registrar) (Registrar's signature)

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. **5025 E. 8th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **8th**
year **1940** hour **8** minute **35 A.** M.
21. I hereby certify that I attended the deceased from **May 31st**, 19 **40**, to **June 8th, 1940**, 19 **40**;
that I last saw him **alive** on **June 8th, 1940**, 19 **40**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**
Due to **23**
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy **See above**

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 **P. D. Dr. Miriam M.D.** (M. D. or other)
Address **Supt. K.C. Gen. Hospital, K.C. Mo.** Date signed _____

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.