

No. 2
4-13-40
5-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 15 1940
399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20966

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2583

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

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:
Kansas City Convalescent Home 3300 Norledge
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether
in this community. Unknown
years, months or days)

3. (a) PRINT FULL NAME Jesse Horseman
3. (b) If veteran, name war Unk.
3. (c) Social Security No. Unk.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Single
6. (b) Name of husband or wife. -- 6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased No record
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 -- -- -- hr. -- min.

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

10. Usual occupation Unknown

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Kansas City Convalescent Home
(b) Address 3300 Norledge

17. (a) Removal (b) Date thereof 6-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Central School of Olathe, Mo.

18. (a) Signature of funeral director Walter
(b) Address 7406 Wornall Road

19. (a) June 25, 1940 (b) M. M. Brown
(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. 3300 Norledge
(If rural, give location)
(e) -If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18
year 1940 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 4
1940, to June 18 1940;
that I last saw him alive on June 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial Infarction
due to arteriosclerosis
due to hypertension
due to arteriosclerosis
due to hypertension
Other conditions General debility
(Include pregnancy within 3 months of death)

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

Major findings:
Of operations _____
Of autopsy _____

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 1
23. Signature W. H. Gray (M. D. or other) W. H.
Address _____ Date signed _____

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.....

Harlyn Roe
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Harlyn Roe

Licensed Embalmer No. *2870*

P. O. Address *7406 Womall St*

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, fact should be so stated above.