FILED AUG 14 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24041

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2651

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 Tuberculosis Hospt. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 months 9 Days (Specify whether years, months or days) In this community 2 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.: 2200½ E. 13th St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME: Ora Sailing Ora Sailing
3. (b) If veteran, name war: No
3. (c) Social Security No.: No

4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: unknown
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: June 1 - 1900 (Month) (Day) (Year)

8. AGE: Years 40 | Months 0 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace: Mississippi (City, town, or county) (State or foreign country)
10. Usual occupation: Common labor.
11. Industry or business:
MOTHER FATHER
12. Name: David Lewis.
13. Birthplace: Mississippi (City, town, or county) (State or foreign country)
14. Maiden name: Frances Crawford
15. Birthplace: Mississippi (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: K.C.T.B. Hospt
(b) Address: Leeds Station.
17. (a) Burial (Burial, cremation, removal) (b) Date thereof: 9 1 40 (Month) (Day) (Year)
(c) Place: burial or cremation: Olive Ridge Lawn
18. (a) Signature of funeral director: Kenney Funeral Home
(b) Address: 1905 E 14
19. (a) July 1, 1940 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26 year 1940 hour 2 minute A. M.
21. I hereby certify that I attended the deceased from Aug. 17, 1939, to June 26, 1940, that I last saw him alive on June 25, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Resp. Failure
Due to: Pulmonary T.B.
Due to:
Other conditions (Include pregnancy within 3 months of death): 23
Major findings: Of operations:
(22) Of autopsy:

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)
(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: O. C. Hayes Med. Supt. (M. D. or other)
Address: K.C.M.T.B. Hospital. Date signed

(Licensed Embalmer's Statement on Reverse Side) Kansas City, Mo.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 — 1 X19511

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 E. Sterling Bills

Licensed Embalmer No. 3178

P. O. Address 1811 E 12th St K.C.

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.