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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

24209

State File No. 2819

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

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

1. PLACE OF DEATH:

(a) County Jackson 1

(b) City or town KANSAS CITY CITY (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: GENERAL HOSPITAL #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 WEEKS 6 DAYS (Specify whether years, months or days)

In this community ABOUT 15 YEARS

2. USUAL RESIDENCE OF DECEASED:

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(a) State MISSOURI (b) County JACKSON

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

(d) Street No. 1310 E 16 (If rural, give location)

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

3. (a) PRINT FULL NAME Lillian Stratton LILLIAN STRATTON 36

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 Marr

6. (b) Name of husband or wife EDWARD STRATTON

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased 7 (Month) 15 (Day) 1890 (Year)

8. AGE: Years 49 Months 11 Days 21 If less than one day ..... hr. ..... min.

9. Birthplace SHERMAN (City, town, or county) TEXAS (State or foreign country) 1

10. Usual occupation LAUNDRY WORK 2

11. Industry or business 1

FATHER
12. Name FORCE EDMONDSON
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country) 4

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

16. (a) Informant EDWARD STRATON

(b) Address 1310 E 16

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-12-40 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge LAWN

18. (a) Signature of funeral director E. Sterling Bells

(b) Address 1811 E 13th St K.C.M.O.

19. (a) July 13, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7-6-40 day year ..... hour ..... minute 8:00 P 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.

Immediate cause of death Toxemia Gravidarum

Due to Suppuration Cellulitis L Thigh

Due to Fall from Roof of Bldg

Other conditions (Include pregnancy within 3 months of death) 186a

Major findings: Of operations 1

Of autopsy ab

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 5-23-40

(c) Where did injury occur? Kansas City Jackson Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home Fall from Bldg (Specify type of place)

While at work? (e) Means of injury

23. Signature Russell W Bern (M. D. or other) 5

Address RCM 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 E. Sterling Bullen

Licensed Embalmer No. 3178

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

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.