V. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492

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

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24263
2873

Registration District No. 399 Primary Registration District No. 1008 Registrar's No.

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: K.C.General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community: Life

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. 912 East 9th St.
(If rural, give location)

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

3. (a) PRINT FULL NAME: MAMIE ISABELL 214

3. (b) If veteran, name war: ----

3. (c) Social Security No. 495-07-8553

4. Sex: Female

5. Color or race: Wh.

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: June (Month) 15 (Day) 1899 (Year)

8. AGE: Years 41 Months 1 Days 1 If less than one day hr. min.

9. Birthplace: (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation: Machine Operator 0

11. Industry or business: Garment Factory 0

MOTHER FATHER

12. Name: Samuel E. Isabell

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

14. Maiden name: Minnie Lester

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

16. (a) Informant: Minnie Lester

(b) Address: 912 East 9th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 19, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Hope

18. (a) Signature of funeral director: Rose & Henderson

(b) Address: Kansas City, Missouri

19. (a) July 18, 1940 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th year 1940 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 13th 40, 19__, to July 16th 1940, 19__; that I last saw him alive on July 16th 1940, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: LOBAR PNEUMONIA	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:

Of autopsy: None

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: Denny R. Thorp (M. D. or other)
Address: Supt. K.C.Gen.Hospital K.C.Mo. Date signed: 7-18-40

(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 G. E. Henderson

Licensed Embalmer No. 3657

P. O. Address K.C. MO

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.