

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27758**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3392**

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 No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
(Specify whether
In this community **37 years.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limit write "RURAL")
(d) Street No. **1412 Park Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **27th**
year **1940** hour **7** minute **15 A.** M.

21. I hereby certify that I attended the deceased from
8-20-40, 19____, to **8-27-40**, 19____;
that I last saw him alive on **8-27-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Internal hemorrhage

Due to **Ruptured gastric arterials**

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)
_____ (or) Means of injury _____

23. Signature **Dwight R. Shore** (M. D. or other) _____
Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

Duration

PHYSICIAN

118
Underline
the cause to
which death
should be
charged sta-
tistically.

3. (a) PRINT FULL NAME **WILLIAM BISHOP** **210**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary Bishopp** 6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **May 17 1874**
(Month) (Day) (Year)

8. AGE: Years **66** Months **3** Days **10** If less than one day
hr. min.

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

10. Usual occupation **Furniture store Employee**

11. Industry or business _____

12. Name **J. L. Bishop**

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

14. Maiden name **Nancy Hensley**

15. Birthplace **No Record**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Bishop**

(b) Address **1412 Park**

17. (a) **Burial** (b) Date thereof **Aug. 30, 40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918 Brooklyn Kansas City Mo.**

19. (a) **Aug. 29, 1940** (b) **M. M. Crowe**
(Data received local registrar) (Registrar's signature)

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

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. 2724

P. O. Address J. E. No

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27758
Registrar's No. 3392

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH
(a) County Jackson
(b) City or town K. C.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Bishop
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8/29/40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month Aug. day 27 - 1940
year _____ hour _____ minute _____ 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 Internal hemorrhage - Ruptured gastric arterials (Gastric polyp of the stomach with ulceration and necrosis of the base and rupture of the underlying artery with result of fatal gastric hemorrhage.)
Due to _____
Due to _____
Other conditions _____
(Specify pregnancy within 3 months of death)

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?
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

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

