No. 2
1-13-40
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34422

Registration District No. NOV 1 - 1940

Primary Registration District No. 1002

Registrar's No. 3938

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 Municipal Tuberculosis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 yrs 2 mo - 2 da (Specify whether
In this community 6 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 limits, write "RURAL")
(d) Street No. 4444 Scarlet
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No. years.

3. (a) PRINT FULL NAME Hart, Dorothy
Hart, Dorothy

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife x

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

7. Birth date of deceased Jan. (Month) 2 (Day) 1910 (Year)

8. AGE: Years 30 Months 9 Days 9 If less than one day hr. min.

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

10. Usual occupation School teacher

11. Industry or business x

MOTHER FATHER
12. Name Hart, Abraham
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name Frilnch, Emma
15. Birthplace Minnesota (City, town, or county) (State or foreign country)

16. (a) Informant K.C.M.B. Hospital
(b) Address Leeds Station

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-13-40 (Month) (Day) (Year)
(c) Place: burial or cremation Annandale, Minnesota.

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 10-13-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11 year 1940 hour 5 minute 55 A.M.

21. I hereby certify that I attended the deceased from Aug 9, 1937 to Oct 11, 1940 that I last saw her alive on Oct. 11, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis Bronchopneumonia Pulmonary TBC, Widespread miliary TBC. — Duration 3 yrs.

Due to

Due to 23

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Same as above.

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. L. Dayer (M. D. or other) 10/
Address C. C. Hospital Kansas City Mo. Date signed 10/14/40.

(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.....

Licensed Embalmer No. 14015

P. O. Address N. C. NO

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

If this body is not embalmed, fact should be so stated above.