

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34445  
Registrar's No. 3961

NOV 12 1940 399  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)  
In this community 9 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6614 E. 16th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Calvin Ray Curtis

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

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

6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 20 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
28 24 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Roy Curtis

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

14. Maiden name Margaret Howard

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

16. (a) Informant Roy Curtis

(b) Address 6614 E. 16th St.

17. (a) Burial (b) Date thereof Oct. 16, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

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

(b) Address 4139 E. 15th St.

19. (a) 10-15-40 (b) M. D. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10-7-40, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on 10-12-40, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Enteritis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Yes

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) (e) Means of injury 1

23. Signature H. M. Sibley (M. D. or other) \_\_\_\_\_

Address 1624 Prof. Bldg. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

Dr. Turkey  
prof. B. B. B.  
1 to 5 - Tuesday

**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. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**