

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

Form 5-17-39
REV. 5-17-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

34535

State File No. _____

Registrar's No. 4051

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10-10-40-10-19-40
(Specify whether years, months or days)
 In this community 27 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL.")
 (d) Street No. 1401 Euclid Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Leon Dixon

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 9 27 1917
(Month) (Day) (Year)

8. AGE: Years 23 Months 0 Days 22 If less than one day
hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Ben Dixon

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

14. Maiden name Blanche Douglass

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

16. (a) Informant's own signature Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 10-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glaberry, Mo.

18. (a) Signature of funeral director Kenney

(b) Address 1905 E 14th

19. (a) 10-22-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 29
 year 40 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from 10-10- 1940, to 10-19- 1940
 that I last saw him alive on 10-19-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Post Operative Shock

Due to Tumor on Jaw.

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) _____

(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) (Means of injury)

23. Signature J. O. DeWard (M. D. or other) _____
 Address Gen. Hosp. #2 Date signed 10-21-40

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 Bell*

Licensed Embalmer No. *3178*

P. O. Address *1811 E. 12th St. KC*

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.

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Registration District No. 399

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution: General Hosp #2
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No. 1401 Euclid
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Leon Edison

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 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..... 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) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

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

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10/22/1948 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19th year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: Tumor on jaw
Malignant
Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

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).....

(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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

