

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4427**

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 **13 days**
In this community **Unknown**
years, months or days

FILED DEC 11 1940

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. **3407 E. 7th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **18th**
year **1940** hour **2** minute **20 P** M.
21. I hereby certify that I attended the deceased from **11-5-40** 19 to **11-18-40** 19.
that I last saw h. **er** alive on **11-18-40** 19.
and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture of femur, accidental fall in home**
Due to _____
Due to _____
Other conditions **Senility**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **IDA J. HARPER**

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

4. Sex **Fe** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **Unknown** **1849**
(Month) (Day) (Year)

8. AGE: Years **91** Months **4** Days **4** If less than one day hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**

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 **H. C. Kennel Hosp.**

(b) Address **H. C. Hos.**

17. (a) **Burial** (b) Date thereof **Nov. 20, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cremated**

18. (a) Signature of funeral director **C. H. Blackman**

(b) Address **2825 Indip. Blvd**

19. (a) **11-20-40** (b) **Dr. J. H. Crow**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy **NONE**

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)

23. Signature **Dr. J. H. Crow** (M. D. or other)

Address **Med. Dir. U.C. Gen. Hospital** Date signed _____

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

H. D. Blackman

Licensed Embalmer No. *3639*

P. O. Address *9855 Indip Bl*

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.