

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41281**
Registrar's No. **4674**

Registration District No. **399** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **1005 Brooklyn**
(d) Length of stay: In hospital or institution **22 years**
In this community **22 years**

3. (a) PRINT FULL NAME **Hattie Counts**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Fe** 5. Color or race **Col**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Sam Counts**
6. (c) Age of husband or wife if alive **14** years
7. Birth date of deceased **April 14 1873**

8. AGE: Years **67** Months **7** Days **21**
If less than one day **hr. min.**

9. Birthplace **South Carolina**

10. Usual occupation **At Home**

11. Industry or business

MOTHER FATHER
12. Name **Hawkins**
13. Birthplace **S. C.**
14. Maiden name **Unknown**
15. Birthplace **Unknown**

16. (a) Informant **Pearl Wright**
(b) Address **1005 Brooklyn**

17. (a) **burial** (b) Date thereof **12/9/40**
(c) Place: burial or cremation **Highland Cem**

18. (a) Signature of funeral director **Hawkins Bros.**
(b) Address **1729 Lydia**

19. (a) **12-9-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **1005 Brooklyn**
(e) If foreign born, how long in U. S. A. ? **22** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **5th**
year **1940** hour **9** minute **8** M.

21. I hereby certify that I attended the deceased from **Dec 1**
1940 to **Dec 5** 1940
that I last saw him alive on **Dec 5**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Haemorrhage**

Due to **g.p.w.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **None**
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) (e) Means of injury

23. Signature **W. W. ...** (M. D. or other)
Address **1612 E 12** Date signed **12/7/40**

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

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.....

Isaac Jerome Maw

Licensed Embalmer No. *3994*

P. O. Address *1120 E 23rd St*

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, fact should be so stated above.