

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1294
Registrar's No. 254

Registration District No. 399 Primary Registration District No. 1002

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 11-26-40-1-15-41
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lucille Shaw
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Chas. Shaw
6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased: 3 (Month) 17 (Day) 1895 (Year)

8. AGE: Years 45 Months 29 Days 29
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Larkin Allen
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Julia Jackson
15. Birthplace Sheridan County
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address Gen. Hosp. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18, 41
(Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director R. E. Davis
(b) Address 312 E. Lexington Independence

19. (a) Jan 18 1941 (Date received local registrar) (b) Dr. M. Criswell (Registrar's signature)

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. 1800 E. 24th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 1 day 15
year 41 hour 3 minute 55 P. M.

21. I hereby certify that I attended the deceased from 11-26- 1941 to 1-15- 1941
that I last saw her alive on 1-15- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Embolic from Heart (Rheumatic in origin)

Due to Avitaminosis

Due to Arthritis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 [Signature] (M. D. or other)
Address Gen. Hosp. #2 Date signed 1-16-41

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

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

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.

Rev. 5-17-39 I xesi

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 Fannie L. Meek
Licensed Embalmer No. 3818
P. O. Address 1707 E. 18th

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.