No. 2
-1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13353

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1334

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 6 days (Specify whether
In this community 20 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3240 Flora 8
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM PAGE B.

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Agnes Page

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

7. Birth date of deceased June - 12 - 1866 (Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 20 If less than one day ✓ hr. ✓ min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Joseph Page
13. Birthplace Dont known (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jessie McCarthy
(b) Address 3240 Flora

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Apr. 4-41 (Month) (Day) (Year)
(c) Place: burial or cremation Kincaid Kan

18. (a) Signature of funeral director N.P. Doehler
(b) Address 1415 E 15

19. (a) Apr 4 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd year 1941 hour 10 minute 50 P. M.

21. I hereby certify that I attended the deceased from March 27th 1941 to April 2nd 1941; that I last saw him alive on April 2nd 1941 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to 932 932

Due to

Other conditions Toxic myocardial degeneration
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy See above

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Wm R Thorn (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed 4-3-1941

(Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.