

No. 2
1-4-41
17-39
X26290

1941 STANDARD CERTIFICATE OF DEATH

State File No. **20661**
Registrar's No. **2191**

Registration District No. **399**

Primary Registration District No. **1002**

FILED JUL 7 1941

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

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 **16 days** (Specify whether
In this community _____
years, months or days)

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. **118 1/2 Independence** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27th**
year **1941** hour **4** minute **15** A.M. M.

21. I hereby certify that I attended the deceased from **May 11th** 19**41** to **May 27th** 19**41**.
that I last saw him alive on **May 27th** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Unresolved broncho pneumonia** Duration _____

Due to **Hypertensive heart disease with decompensation**

Due to **73 H**
Other conditions **93 H**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **None**
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? _____ (Specify type of place) _____
23. Signature **Dr. R. C. Shaw** (M. D. or other) **0**
Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

3. (a) PRINT FULL NAME **JAMES KEENE**

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

4. Sex **M. O** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Widower**

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

7. Birth date of deceased **Oct. 10th 1861**
(Month) (Day) (Year)

8. AGE: Years **79** Months **7** Days **17** If less than one day _____ hr. _____ min.

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

10. Usual occupation **None**

11. Industry or business _____

12. Name **Richard Keene**

13. Birthplace **No record** (City, town, or county) (State or foreign country)

14. Maiden name **No record**

15. Birthplace **No record** (City, town, or county) (State or foreign country)

16. (a) Informant **Record clerk**

(b) Address **K.C. General Hospital**

17. (a) _____ (b) Date thereof **6-4-41** (Month) (Day) (Year)

(c) Place: burial or cremation **State Cust. Spd**

18. (a) Signature of informant **Wm. A. [Signature]**

(b) Address **Wm. A. [Signature]**
19. **June 6 1941** (Date received local registrar) (b) **M. M. Brown** (Registrar's signature)

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.....

Wm. A. Johnson

Licensed Embalmer No..... **3089**.....

P. O. Address.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1002

State File No. 20661
2191
Registrar's No.

Registration District No.

Primary Registration District No.

Registrar's No.

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

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 #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME James Keene

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Unknown 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hr. _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7/10/41 (b) M. M. Brown (Date received local registrar) (Registrar's signature)

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. 118 1/2 Indep. Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27th year 1941 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 Pulmonary embolism

Due to Sarcoma of left parietal pleura

Due to _____

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

Major findings: Of operations _____

Of autopsy See above

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 Drury R. Show (M. D. or other) _____

Address Med. Dir. K. Gen. Hospital Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

