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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20690

Registration District No. FILED JUL 7 1941 Primary Registration District No. 1002 Registrar's No. 2220

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1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. T.B. Hospital (Leeds) O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mo - 28 da (Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Rural's City
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. # 1, Hickman Mills
(If rural, give location)
(e) If foreign born, how long in U. S. A.? -- years.

3. (a) PRINT FULL NAME Sesris Y - Viola Y Rose
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm. G. Sesriet
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased September (Month) 15 (Day) 1901 (Year)
8. AGE: Years 39 Months 8 Days 23 If less than one day hr. min.
9. Birthplace Lawrence (City, town, or county) Kan (State or foreign country)
10. Usual occupation Housewife
11. Industry or business -
MOTHER FATHER
12. Name Rose - Jasper
13. Birthplace Lawrence (City, town, or county) Kan (State or foreign country)
14. Maiden name Gaines - Nellie
15. Birthplace Kansas (City, town, or county) (State or foreign country)
16. (a) Informant K.C. T.B. Hosp.
(b) Address Leeds Sta. Mo. Kansas City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery
18. (a) Signature of funeral director J. A. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.
19. (a) June 9 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8th year 1941 hour 3 am minute M.
21. I hereby certify that I attended the deceased from Jan 14, 1941, to June 8th, 1941; that I last saw her alive on June 7, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death* Laryngeal tuberculosis	
Due to* Chronic pulmonary tuberculosis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 12 B	
Major findings: Of operations 12 D	
Of autopsy	

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 (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. O. Newcomer Jr.

Licensed Embalmer No. 4043

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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