

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24080
2619
Registrar's No. _____

FILED AUG 16 1941
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: 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 years, months or days)

In this community 30 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. 2024 Indiana
(If rural, give location)

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

3. (a) PRINT FULL NAME JAMES S. PROCK

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 Married

6. (b) Name of husband or wife Minnie May Prock

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased September 22 - 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

82 9 19 _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Ambrose Prock

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

14. Maiden name Jane Pennington

15. Birthplace No Record?
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Bernie Prock

(b) Address 2024 Indiana

17. (a) Removal (b) Date thereof July 12 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eldorado Springs MO

18. (a) Signature of funeral director Mrs. C. D. Foster

(b) Address 361

19. (a) 7-11-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11th
year 1941 hour 5 minute 50 A. M.

21. I hereby certify that I attended the deceased from 7-5-41 to 7-11-41, 1941;
that I last saw him alive on 7-11-41, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia, terminal

Due to 1070

Due to 107

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

Major findings:
Of operations _____

Of autopsy See above

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? _____

While at work _____ (Specify type of place)
(c) Means of injury _____

23. Signature Drury R. Thow (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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 *Theron A. Redmon*

Licensed Embalmer No. *2737*

P. O. Address. *K.C. Mo.*

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.