No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 16 1941

Registration District No. 99

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 24241

Registrar's No. 2780

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

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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: Mercy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours (Specify whether years, months or days)
In this community 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cass 019
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 5 miles West Kansas City
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Marrion Christenson
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 Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased March 14 1939 (Month) (Day) (Year)

8. AGE: Years 2 Months 4 Days 10 If less than one day hr. min.

9. Birthplace Lee County (City, town, or county) Mo. (State or foreign country)
10. Usual occupation —
11. Industry or business —
FATHER 12. Name Albert Christenson
13. Birthplace Illinois (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Nora Anderson
15. Birthplace Lee Co. (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Nora Christenson
(b) Address Harrisonville Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25-41 (Month) (Day) (Year)
(c) Place: burial or cremation Pitts Chapel
18. (a) Signature of funeral director Rennenberger Bros
(b) Address Harrisonville Mo
19. (a) 7/25/41 (Date received local registrar) (b) M. M. Crouse (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1941 hour 8:0 minute 20 A. M.
21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw h... alive on ..... 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diphtheria	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
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 E. J. Glossock (M. D. ~~or other~~) D
Address Prof. Bldg. Date signed 7-25-41

(Licensed Embalmer's Statement on Reverse Side)

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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 wi the above constitutes grounds for revocation of license.)

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