

No. 2
1-4-41
17-39

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24333

State File No. _____

X263

Reg. Dist. No. 16 399

Primary Registration District No. 1002

Registrar's No. 2872

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 outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 3 days
(Specify whether In this community 2 yrs 0 years, months or days) (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City 090
(If outside city or town limits, write "RURAL")

(d) Street No. 2503 Bellefontaine
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Littlepage, Thomas Golden

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29th
year 1941 hour 10 minute 58 P. M.

21. I hereby certify that I attended the deceased from 7-24-41 19, to 7-29-41 19;
that I last saw him alive on 7-29-41 19;
and that death occurred on the date and hour stated above.

4. Sex M. 5. Color of race W

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

6. (b) Name of husband or wife Ludine Jane Lamb 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased: 6 10 1888
(Month) (Day) (Year)

Immediate cause of death: Rheumatic Heart Disease with mitral stenosis

Due to _____

Due to _____

Other conditions: _____
(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.

8. AGE: Years 53 Months 1 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace State of Kentucky 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name no record

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 Mrs. G. E. Wilson
(b) Address 2503 Bellefontaine

17. (a) Removal (b) Date thereof 7/30/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain Grove Mo

18. (a) Signature of funeral director John P. Stahl
(b) Address Kansas City Mo

19. (a) 7/30/41 (b) M. Th. Crown
(Date received local registrar) (Registrar's signature)

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) (a) Means of injury _____

23. Signature Amey R. Thore (M. D. or other) P
Address Med. Dir. A. G. Gen. Hospital Date signed _____

FEB 25 1949

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 with the above constitutes grounds for revocation of license.)

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