

No. 2
-1-4-41

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24351

State File No.

2890

AUG 10 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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 #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7-22-41-7-27-41
16 years 0 (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 048
(c) City or town Kansas City 5
(If outside city or town limits, write "RURAL")
(d) Street No. 1521 Euclid Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME William Hendricks

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased 12 25 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>7</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 7 30 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director Adkins Bros.

(b) Address 2000 E. 16th St. C. Mo.

19. (a) 7-31-41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 27
year 41 hour 8 minute 50 A. M.

21. I hereby certify that I attended the deceased from 7-22-
1941 to 7-27- 1941
that I last saw him alive on 7-27- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Ruptured Artery of Stomach Causing Severe Hemorrhage

Due to Carcinoma of Stomach

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 R. P. ... (M.D. or other) _____

Address Gen. Hosp #2 Date signed 7-27

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

(Licensed Embalmer's Statement on Reverse Side)

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

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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 Edwin Evans
Licensed Embalmer No. 3806

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.