

S. No. 2  
M-1-4-41  
v. 5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

25265

State File No. \_\_\_\_\_

FILED AUG 19 1941

Registration District No. 404

Primary Registration District No. 5558

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (c) County Jackson  
 (b) City or town Kennett City, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Trinity Lutheran Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 89 yrs (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town St. James  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 78th (If rural, give location)  
 (e) Citizen of foreign country? - (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Kemp Mockbee  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month June day 30  
 year 1941 hour 8 minute 50 a.m.

4. Sex M. 5. Color or race W  
 6. (a) Single, widowed, married, divorced 1  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
 alive \_\_\_\_\_ years  
 7. Birth date of deceased 12 25 1853  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
March 1934, to June 30 1941  
 that I last saw him alive on June 30 1941  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Hyperthrophy of the prostate Duration 1 year

**8. AGE:** Years 87 Months 6 Days 5 If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to 1370

9. Birthplace Jackson Mo (City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer  
 11. Industry or business \_\_\_\_\_

Other conditions Hemiplegia 8 years ago  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**MOTHER**  
 12. Name Thomas Mockbee  
 13. Birthplace Kentucky (City, town, or county) (State or foreign country)  
 14. Maiden name Eliza Childs  
 15. Birthplace Kentucky (City, town, or county) (State or foreign country)

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?

16. (a) Informant Mrs. Annie Wood  
 (b) Address 7800 Holmes  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 1941 (Month) (Day) (Year)  
 (c) Place: burial or cremation Forest Hill

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature R. C. Oragan (M. D. or other) \_\_\_\_\_  
 Address 404 1/2 W 75th Date signed 7-2-1941

18. (a) Signature of funeral director [Signature]  
 (b) Address 7406 W. Marshall Rd.  
 19. (a) \_\_\_\_\_ (Date received local registrar) (b) [Signature] (Registrar's signature)

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.....

*Harlyn Roe*.....; Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Harlyn Roe*  
Licensed Embalmer No. *2810*

P. O. Address *1. 6mo*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 404

Primary Registration District No. 5558

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: Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community all his life  
years, months or days)

3. (a) PRINT FULL NAME Kemp Mackbee

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased Dec 25 - 1853  
(Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days 5 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

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

10. Usual occupation James V. P. D. Mo

11. Industry or business \_\_\_\_\_

12. Name Thomas Mackbee

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

14. Maiden name Eliza Childs

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

16. (a) Informant Mrs. Annie Wood

(b) Address 784 Holmes

17. (a) \_\_\_\_\_ (b) Date thereof 6-2-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Harlyn Rae

(b) Address 7406 Wornale

19. (a) \_\_\_\_\_ (b) R. V. Lindsay (Registrar's signature)  
(Date received local registrar) (City)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 78 and Holmes (Rural)  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30  
year 1941 hour 6:10 am minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
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 Dr. R. C. Reagan (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

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

MOTHER FATHER

R. V. Lindsay  
Ray  
Assoc. H. Keeler

Letter from Roscoe Kester. 1-4-41 -  
give place of death as in notes and  
Kramer - letter to K.C. Woodhead  
Dyck - for verification

S-25265

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 4-14

Primary Registration District No. 5-5

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: Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: in hospital or institution (Specify whether  
In this community all his life  
years, months or days)

3. (a) PRINT FULL NAME Kemp Mackbee  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation

11. Industry or business

12. Name

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

(b) Address

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director R. L. Lindsay & Sons

(b) Address By Passcoe H. Mueller

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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. 18 and Homes (Rural)  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH Month June day 30  
year 1991 hour 6:10 am minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3400

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: Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days) 87 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town K.C. (If outside city or town limits, write "RURAL")  
(d) Street No. 98 and Home (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Kemp Mockbee  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month June Day 30 Year 1941 Hour 12 Minute 50 am

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased December 25 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 9 to June 30, 1941; that I first saw him alive on June 30, 1941; and that death occurred on the date and hour stated above. Immediate cause of death: Syphilitic proctate Duration 1 year

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Jackson Mo. (City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Other conditions Hemiplegia syphilitic  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name Thomas Mockbee  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name Elena Childs  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Annie Wood  
(b) Address 1800 James  
17. (a) Burial (b) Date thereof July 2, 1941 (Month) (Day) (Year)  
(c) Place: burial or cremation Trinity Lutheran

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? \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 7406  
19. (a) 7/16/1941 (b) H. J. [Signature] (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature R.C. Pagan (M. D. or other)  
Address 4042 9th St Date signed 7-1-1941

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

MOTHER FATHER

SUPPLEMENTARY