

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

27291

FILED SEP 12 1941  
Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

2949

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 3-10-41-7-24-41  
(Specify whether  
In this community 18 years  
years, months or days)

3. (a) PRINT FULL NAME Ide Nash  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security 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 1 30 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 6 24 hr. min.

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

10. Usual occupation None

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 Gen. Hosp. #2  
17. (a) Burial (b) Date thereof 8-5-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deceased

18. (a) Signature of general director Wm. A. Johnson

(b) Address City Registrar

19. (a) 8/4/41 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. Jackson County Home  
(If rural, give location)  
(e) Citizen of foreign country? 4 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 24  
year 41 hour 12 minute 45 A. M.

21. I hereby certify that I attended the deceased from 3-10- 1941 to 7-24- 1941  
that I last saw h. im. alive on 7-24- 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Duration \_\_\_\_\_

Due to Ascending Pyelonephrosis

Due to 133a

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 133a  
Of operations \_\_\_\_\_

Of autopsy Above Mentioned

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 [Signature] (D. or other) \_\_\_\_\_  
Address Gen. Hosp. #2 Date signed 7-29-41

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

MOTHER FATHER

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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 with the above constitutes grounds for revocation of license.)**

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