

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30684

State File No.

Registrar's No.

3441

FILED OCT 13 1941
Registration District No. 299

Primary Registration District No. 1002

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 6-12-41-9-9-41
(Specify whether
In this community 15 years, months or days)

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. 1018 Tracy
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9
year 1941 hour 8 minute 50 p.a.m.

21. I hereby certify that I attended the deceased from
June 12, 1941 to September 9, 1941
that I last saw him alive on September 9, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
Fibrinous pericarditis with
hemorrhage into pericardial sac
Due to Marked pulmonary edema &
congestion

Other conditions
(Include pregnancy within 3 months of death) None

Major findings:
Of operations 90K
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?

While at work? (Specify type of place) Means of injury
23. Signature [Signature] (M.D. or other)
Address Gen. Hosp #2 Date signed 9-11-41

3. (a) PRINT FULL NAME CHARLES WILLIAMS
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race Negro 6. (e) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Sister 6. (c) Age of husband or wife if alive Chrisola Wright years
7. Birth date of deceased September 7 1894
(Month) (Day) (Year)

8. AGE: Years 47 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER { 12. Name Deceased
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Deceased
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof Sept 15-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation General Hospital #2

18. (a) Signature of funeral director [Signature]
(b) Address [Address]

19. (a) 9/15/41 (b) M. M. Crowe
(Date received local registrar) (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.....
....., 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.