

No. 2
1-4-41
17-39
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30892

State File No.

Registration District No. 29

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County JAYSON
(b) City or town KANSAS CITY MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST JOSEPH HOSPITAL 19
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ONE HOUR
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE
(c) City or town HIGGINSVILLE MO
(If outside city or town limits, write "RURAL")
(d) Street No. 1202 SHELBY
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 9
year 1941 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from Crown Case 19____ to 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Shock to heart & brain from gunshot wound of abdomen Duration 2 hrs
Due to _____

Due to _____
Other conditions (Include pregnancy within 3 months of death) 1941
Major findings: 371

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Gunshot wound of abdomen

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 10-9-41
(c) Where did injury occur? at his home 054
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work? yes (Specify type of place) (e) Means of injury 3
23. Signature Dr. Martin (M.D. or other)
Address 1202 Shelby Date signed 11-9-41

3. (a) PRINT FULL NAME KATHERINE VIRGINIA POISAL

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased SEPT 12 1920
(Month) (Day) (Year)

8. AGE: Years 16 Months 27 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation STUDENT

11. Industry or business HIGGINSVILLE HIGH SCHOOL

12. Name ED POISAL

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

14. Maiden name FRANCIS HORNER

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

16. (a) Informant MINNIE OLIVER

(b) Address HIGGINSVILLE MO

17. (a) BURIAL (b) Date thereof OCT 12 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director E. S. JAMES

(b) Address CONCORDIA MO

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

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

17
03

RECEIVED
District Health Officer No. 8,
District File Number: _____
Date Filed: 10-13-91

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 *me*

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed

E. S. James

Licensed Embalmer No.

2058

P. O. Address

Concordia Mo

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. 30892

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: St Joseph Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1 hr (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Katherine U Poisal

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

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

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

7. Birth date of deceased Sept. 12, 1922
(Month) (Day) (Year)

8. AGE: Years 16 Months _____ Days _____ If less than one day _____ 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 _____

(b) Address _____

19. (a) Dec-11-41 (b) Tiffany Walsh
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Higginsville MO
(If outside city or town limits, write "RURAL")
(d) Street No. 1262 Shelby
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1941 hour _____ 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 _____

Duration

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

Handwritten notes on the left margin.

1941

S-30892