No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1940

Registration District No. 299

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 33783

Registrar's No. 3714

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town KC Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Genl Hosp #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether)

In this community Unknown (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 49

(c) City or town KC Mo (If outside city or town limits, write "RURAL")

(d) Street No. 1505 Harrison (If rural, give location)

(e) Citizen of foreign country? no (~~Yes or~~ No)

If yes, name country n

3. (a) PRINT FULL NAME CHARLES CASH

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M V

5. Color or race negro

6. (a) Single, widowed, married, divorced Dont Know

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Sep (Month) 26 (Day) 1891 (Year)

8. AGE: Years 50 Months 0 Days 1 If less than one day ..... hr. ..... min.

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

10. Usual occupation Common Laborer

11. Industry or business Dont Know

FATHER
12. Name Calvin Cash
13. Birthplace Dont Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Bettie Johnson
15. Birthplace Dont Know (City, town, or county) (State or foreign country)

16. (a) Informant Susie Young

(b) Address 212 Parallel

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-41 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Flynn & Greenstreet

(b) Address 1819 E. 15th KC Mo

19. (a) 10/6/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 27 year 41 hour 7:30 minute P.M.

21. I hereby certify that I attended the deceased from ..... 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 Bilateral pulmonary tuberculosis

Due to Cavitation

Tuberculous enteritis

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 13 P

Of autopsy

Duration

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] (M. D. or other) 3

Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. 3836

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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