

3-40
K23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33849**
Registrar's No. **3785**

FILLED NOV 13 1941
Registration District No. **2999**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH: **Jackson**

(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 **R.C. Gen. Hospital No. 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **26 days**
(Specify whether years, months or days)

In this community **39 Years**

3. (a) PRINT FULL NAME **Sadibelle Beene**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **493-12-0170**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **Mr. Jack Beene**

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

7. Birth date of deceased **December 25 1884**
(Month) (Day) (Year)

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

56 9 12 hr. min.

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

10. Usual occupation **Sewing**

11. Industry or business **W. P. A.**

12. Name **Isaac Lowrey**

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

14. Maiden name **unknown Bushyhead**
(City, town, or county) (State or foreign country)

15. Birthplace **Indian Territory, Okla.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Ray Houghton**
3141 Donnelly Avenue

17. (a) **Cremation** (b) Date thereof **Oct. 11 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **St. Mary's**
(City, town, or county) (State or foreign country)

18. (a) Signature of funeral director **D. H. Newcomer's Sons**

(b) Address **1401 Brush Creek Blvd.**

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

MOTHER FATHER

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **048**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **3943 Brooklyn Avenue**
(If rural, give location)

(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **6th**
year **1941** hour **7** minute **25 P. M.**

21. I hereby certify that I attended the deceased from **9-10-41**, 19, to **10-6-41**, 19, that I last saw her alive on **10-6-41** and that death occurred on the date and hour stated above.

Immediate cause of death **GENERALIZED ARTERIOSCLEROSIS**
Bilateral pyelonephritis
Tuberculosis of Spine

Due to **11/6**

Other conditions **1/6**
(Include pregnancy within 3 months of death)

Major findings: Of operations **1/6**

Of autopsy **none**

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? _____

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature **James R. Hone** (M. D. or other) **0**
Address **Med. Dir. K. P. Gen. Hospital** Date signed _____

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.....

W. Robert Simpson
Licensed Embalmer No. *3965*

P. O. Address *Kansas City, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 329

Primary Registration District No. 1002

Registrar's No. 3785

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:
K. C. General 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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. 3943 Brooklyn Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Sadibelle Beene

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 _____

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 56 yrs. Months _____ Days _____
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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct. day 6th
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 Diabetes Mellitus (Clinical)
Osteomyelitis of the 4th lumbar vertebra
with perivertebral abscess; Chronic
Hyelonephritis with pyonephrosis.

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

Major findings:
Of operations _____

Of autopsy See above for autopsy diagnosis

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 James R. Shaw (M. D. or other) _____
Med. Dir. K.C. Gen. Hospital Date signed 3-13-42
Address _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

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7-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3785

1. PLACE OF DEATH: Jackson

(a) County.....

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

(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

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

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

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

(e) Citizen of foreign country?.....
(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME SADIEBELLE BEENE

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

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

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 Months Days If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER { 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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

19. (a) 2/27/47 M. M. Crow (b).....
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6th
year 1947 hour 7 minute 25 P. M.M.

21. I hereby certify that I attended the deceased from 9-10-41, 19....., to 10-6-47, 19.....;

that I last saw her alive on 10-6-47, 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death DIABETES (CLINICAL) Osteomyelitis of the 4th lumbar vertebra with perivertebral abscess; chronic pyelonephritis with pyonephrosis.

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....
See above

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 Dr. R. K. Thon (M. D. or other).....
Med. Dir. K.C. Gen. Hospital K.C. Mo.
Address..... Date signed.....

(Licensed Embalmer's Statement on Reverse Side)

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

SUPPLEMENTARY

33849

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 the above constitutes grounds for revocation of license.)

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