

No. 2
1-4-41
17
X28393

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37374

State File No. 4169

DEC 22 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community Unknown years, months or days)

3. (a) PRINT FULL NAME NOLASIO, TOMATED

3. (b) If veteran, name war Unk 3. (c) Social Security No. 351-07-9320

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

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 45 Months Days If less than one day hr. min.

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

10. Usual occupation Unknown

11. Industry or business

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Unknown (b) Address Unk?

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11/10/41 (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill Cem. P.C.T.

18. (a) Signature of funeral director Schubert (b) Address 904 E 5th
19. (a) 11-10-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town J. C.
(If outside city or town limits, write "RURAL")
(d) Street No. 507 Walnut (If rural, give location)
(e) Citizen of foreign country? P (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 6 1941
year hour minute M.

21. I hereby certify that I attended the deceased from 8:20 a. to 19:

that I last saw physically live on 19: and that he died on the date and hour stated above.

Immediate cause of death stab wounds of abdomen

and chest

Due to 167

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy UPO

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) homicide

(b) Date of occurrence 11-6-41

(c) Where did injury occur? K.P. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? dent house (e) Means of injury stab

23. Signature Crowe (M. D. or other) Address K.P. Mo Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Ray E Snow*.....

Licensed Embalmer No. *2560*

P.O. Address *1807 E 29th*

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.