

DEC 22 1941 399
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4274

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 No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-10-41- 5 1/2 hr
In this community unknown
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. 1712 Forest
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10
year 1941 hour 6 minute 45 p. M.
21. I hereby certify that I attended the deceased from 1:20 p.m. - 6:45
November 10, 1941 to November 10, 1941
that I last saw her alive on November 10, 1941
and that death occurred on the date and hour stated above.
Immediate cause of death Eclampsia ✓

Duration

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

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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? _____ (Specify type of place)
Means of injury _____
23. Signature J. C. Brown (M. D. or other)
Address Gen Hospital - 600 E. 22nd Date signed 11-13-41

3. (a) PRINT FULL NAME VALLIE D. THOMPSON

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

4. Sex Female 5. Color or race Negro 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 May 27 1896
(Month) (Day) (Year)

8. AGE: Years 45 Months 5 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Deceased

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

14. Maiden name Deceased

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation Blue Ridge Cem

18. (a) Signature of funeral director Ideal Fun Home

(b) Address 1409 E. 22nd St

19. (a) 11-17-41 (b) J. M. Brown
(Date received local registrar) (Registrar's signature)

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

48

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.....

L. Harris

Licensed Embalmer No. *3388*

P. O. Address *K. C. 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.

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Registration District No.

Primary Registration District No. 1002

Registrar's No. 4274

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 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.....
years, months or days)

3. (a) PRINT FULL NAME **Vallie D. Thompson**

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
	45	5	14 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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)..... (b) **M. M. Brown** (Registrar's signature)
(Date received local registrar)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **10**
year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 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.....
Eclampsia

Due to **Pregnancy**

Due to.....

Other conditions..... **Date of delivery**
(Include pregnancy within 3 months of death) **11-10-41**
Mother died after delivery
She aborted with a dead fetus

Of autopsy.....

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?..... (c) Means of injury.....
Signature..... (M. D. or other)
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT

5-37479

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37479
Registrar's No. 4274

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME

Kellie D. Thompson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____

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

7. Birth date of deceased

(Month) May

(Day) 27

(Year) 1949

8. AGE:

Years 45

Months 5

Days _____

If less than one day _____ min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry of 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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1949 Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him/her live on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Pregnancy

Due to 144a

Other conditions: Date of delivery 11/10/41
(Include pregnancy within 8 months of death)

Major findings: Mother died after delivery
Of operations: aborted, dead foetus

Of autopsy _____

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 _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.