

No. 2  
9-4-41  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41086  
State File No.  
4767  
Registrar's No.

11 JAN 24 1941 399  
Registration District No.

1002  
Primary Registration District No.

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: 3215 Campbell  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether)

In this community 6 weeks  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 048  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 3215 Campbell  
(If rural, give location)

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

If yes, name country NO

3. (a) PRINT FULL NAME John H. LAYTON

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Theresa Layton

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

7. Birth date of deceased May 16 - 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6/10/37  
~~1937~~ 1937, to 12/20 1941  
that I last saw him alive on 11/28 1941  
and that death occurred on the date and hour stated above.

8. AGE: Years 62 Months 7 Days 5 If less than one day \_\_\_\_\_ min.

Immediate cause of death Ch. Myocarditis  
Arteriosclerosis

Due to arteriosclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) f31

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

10. Usual occupation Stationary Fireman

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Mr. Stephen P. Jones

(b) Address Julia, Mo.

17. (a) Burial (b) Date thereof 12-22-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galveston, Tex.

18. (a) Signature of funeral director George B. Carson

(b) Address Independence, Mo.

19. (a) 12/22/41 (b) Dr. M. K. Krome  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature Dr. Krome (M. D. or other) MD

Address 10307 Independence Date signed 12/24/41

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

#80

**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.....

*Raymond N. Martin*

Licensed Embalmer No. *4150*

P. O. Address.....

*Independence 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.**