

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED FEB 11 1942

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 1277

Registrar's No. 264

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 **12-28-41-1-18-42**  
(Specify whether years, months or days)  
In this community **24 years**

3. (a) PRINT FULL NAME

**AMANDA JAMES**

3. (b) If veteran, name war  
3. (c) Social Security No. **495-09-4081**  
4. Sex **Female** 5. Color or race **Negro** 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 **August 5 1892**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**49 5 3** hr. min.

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

10. Usual occupation **Unemployed**

11. Industry or business

12. Name **Deceased Unknown**  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name **Deceased**  
15. Birthplace (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 **1 21 42**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Westlawn, K.C.M.**

18. (a) Signature of funeral director **Adkins Bros.**  
(b) Address **1200 E. 17th St. K.C. Mo.**

19. (a) **1/20/42** (b) **M. H. Brown**  
(Date received local registrar) (Registrar's signature)

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. **1318 Woodland**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **18**  
year **1942** hour **4** minute **50** p. M.

21. I hereby certify that I attended the deceased from **December 28 1941** to **January 18 1942**  
that I last saw her alive on **January 18 1942**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Caseous Pneumonia**

Due to **Far Advanced Pulmonary Tuberculosis**

Due to **13 B1**  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

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?

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

23. Signature **G. C. Brown** (M. D. or other)  
Address **Gen. Hosp. #2-600 E. 22nd** Date signed **1/19-42**

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

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.**