No. 2
4-13-40
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1949

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5366

Registration District No. 399 Primary Registration District No. 602 Registrar's No. 791

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 #2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days (Specify whether years, months or days)
In this community 18 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48 8
(c) City or town Kansas City, (If outside city or town limits, write "RURAL")
(d) Street No. 2444 Forrest (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME ARCHIE HANKINS
3. (b) If veteran, name war —
3. (c) Social Security No. None 496-07-1338
4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married or divorced married
6. (b) Name of husband or wife Della May Hankins 6. (c) Age of husband or wife if alive 24 years
7. Birth date of deceased 12 (Month) 1 (Day) 1914 (Year)
8. AGE: Years 27 Months 2 Days 19 If less than one day ..... hr. ..... min.
9. Birthplace Dequeen (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Car Porter Helper
11. Industry or business
MOTHER FATHER
12. Name Sam Hankins
13. Birthplace Dequeen (City, town, or county) Arkansas (State or foreign country)
14. Maiden name Grace Murphy
15. Birthplace Lockesburg (City, town, or county) Ark (State or foreign country)
16. (a) Informant Mrs Grace Grant
(b) Address 2444 Forrest
17. (a) Disposal Removal (Burial, cremation, or removal) (b) Date thereof 2-26-42 (Month) (Day) (Year)
(c) Place: burial or cremation Dequeen Arkansas
18. (a) Signature of funeral director A. G. Moor
(b) Address 1820 E. 18th St
19. (a) 2/26/42 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day 2-21-42
year ..... hour ..... minute 35 P.M.
21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19..., 12 ..... 19..... ;
that I last saw him alive on ..... 19..... ;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Acute generalized peritonitis
Due to Gunshot wound of abdomen

Other conditions (Include pregnancy within 3 months of death) 166

Major findings:
Of operations
Of autopsy Yes

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) Homicide
(b) Date of occurrence 2-17-42
(c) Where did injury occur? K C (City or town) Jackson (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work (e) Means of injury
23. Signature Robert Mehlen (M. D. or other)
Address K C Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

Exell

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 me

H B Moore, Registered Apprentice No.

working under my personal supervision.

Signed H B Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E 18th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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