

9729

State File No. _____

Registrar's No. 1297

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FIRED APR 25 1942
Registration District No. 579

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: St Marys Hosp.
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 9 Days
(Specify whether years, months or days)

In this community 9 Days

3. (a) PRINT FULL NAME Howard Lines

8. (b) If veteran, name war no

8. (c) Social Security No. none

4. Sex Male

5. Color or race White

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 Nov. 8 1903
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>38</u>	<u>4</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation Shamrock Body & Bench Shop

11. Industry or business Car finishing

MOTHER FATHER

12. Name Geo. O. Sines

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

14. Maiden name Mildred Andrews

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

16. (a) Informant's own signature Hospital records

(b) Address H.C. no

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof 4-2-42
(Month) (Day) (Year)

(c) Place: burial or cremation Olathe Kas.

18. (a) Signature of funeral director H.E. Julian

(b) Address Olathe, Mo.

19. (a) 4-2-42 (Date received local registrar)

(b) M. M. Grove (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas

(b) County Johnson

(c) City or town Olathe
(If outside city or town limits, write "RURAL")

(d) Street No. Cash Santa Fe
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 1-20-42
_____, 19____, to 4-2-42, 19____;

that I last saw him alive on April 1, 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 5 days

Due to Acute nephritis Since 1-20-42

Due to Hypertension

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

Major findings: Of operations None performed

Of autopsy None performed

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)

(a) Means of injury _____

23. Signature C.W. James (M. D. & S. D.)

Address 133 E. Park, Olathe, Ks. Date signed 4-2-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 H E Julien
Licensed Embalmer No. 2042
P. O. Address Claitor Kas.

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. 1297

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town.....
 (c) Name of hospital or institution:
St. Marys Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community..... (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Howard Lines

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..... year.....

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

8. AGE: Years Months Days If less than one day
38 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..... (City, town, or county) (State or foreign country)

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 6/30/42 (b) M. H. Crow (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 2nd
 year 1942 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 Uremia

Due to Acute nephritis

Due to Hypertension — Acute

Other conditions..... (Include pregnancy within 3 months of death) 130

Major findings: Of operations.....

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.....

Duration.....
 PHYSICIAN.....
 Underline the cause to which death should be charged statistically.

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