

FILED MAY 21 1942

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1864

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 4-29-42-4-30-42
(Specify whether
In this community unk
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. 1320 Lydia
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MALISSA LANGFORD

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive unk years

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

8. AGE: Years app. 60 Months Days If less than one day hr. min.

9. Birthplace unk (City, town, or county) (State or foreign country) 0

10. Usual occupation none

11. Industry or business unk

12. Name unk

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

14. Maiden name unk

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-42 (Month) (Day) (Year)

(c) Place: burial or cremation Seeds

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

(b) Address H. C. Adams

19. (a) 5-12-42 (Date received local registrar) (b) M. N. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30 year 1942 hour 3 minute 00 p.m.

21. I hereby certify that I attended the deceased from April 29 19 42 to April 30 19 42 that I last saw her alive on April 30 19 42 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy

Due to Hypertensive type heart disease

Due to 935

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 E. C. Thomas (M. D. or other)

Address Gen. Hospital 2-6026.22 Date signed 5-11-42

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

MOTHER FATHER

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.