

S. No. 2  
[—9-4-41  
. 5-17-39  
PI X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20465

State File No. \_\_\_\_\_

FILED JUN 27 1942  
299

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 2329

1. PLACE OF DEATH:  
 (a) County... Jackson  
 (b) City or town... Kansas City  
 (c) Name of hospital or institution:  
 K.C. General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 4 days  
 In this community. 41 yrs -  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State. Missouri (b) County. Jackson 48  
 (c) City or town. Kansas City 3  
 (d) Street No. 800 Linwood 8  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country.

3. (a) PRINT FULL NAME Joseph Troupe

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

4. Sex male  
 5. Color or race white  
 6. (a) Single, widowed, married, divorced, married  
 6. (c) Age of husband or wife if alive. 67 years  
 7. Birth date of deceased. May 4 1871  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
 71 1 10 hr. min.

9. Birthplace. Dayton Ohio  
 (City, town, or county) (State or foreign country)

10. Usual occupation. Interior Decorator

11. Industry or business. Self-

12. Name. George Troupe

13. Birthplace. No Record  
 (City, town, or county) (State or foreign country)

14. Maiden name. Amanda Beaver  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Anna Maria Troupe

(b) Address. 800 Linwood

17. (a) Burial (b) Date thereof. June 16 1942  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Green Lawn

18. (a) Signature of funeral director. M. C. R. Foster

(b) Address. 718 Broadway

19. (a) 6-15-42 (b) M. M. Brown  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th  
 year 1942 hour 10 minute 20 A.M. M.

21. I hereby certify that I attended the deceased from 6-10-42, 19, to 6-14-42, 19, that I last saw him alive on 6-14-42, 19, and that death occurred on the date and hour stated above.

Immediate cause of death. Acute hemorrhagic pancreatitis

Due to. 128

Due to.

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

Major findings: Of operations.

Of autopsy. See above

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. D

23. Signature. M. R. Johnson (M. D. or other)

Address. Med. Dir. K. C. Gen. Hospital Date signed 6-15-42

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

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

MOTHER FATHER

361

(Licensed Embalmer's Statement on Reverse Side)

**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.