

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23667

State File No.

FILED AUG 19 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3044

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 8-8-42-8-9-42
In this community 12 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2320 Tracy
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME ERNEST WHITE

3. (b) If veteran, name war None 3. (c) Social Security No. 495-07-7665

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Fannie White 6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased December 24 1905
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>7</u>	<u>16</u>	hr. min.

9. Birthplace Denver Colorado
(City, town, or county) (State or foreign country)

10. Usual occupation Cook

11. Industry or business

MOTHER FATHER {
 12. Name James White
 13. Birthplace Unk. 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Green
 15. Birthplace Unk. 9
 (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 8/12/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem

18. (a) Signature of funeral director Hathorn Bros

(b) Address 1729 Ly dia

19. (a) 8-12-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9
year 1942 hour 2 minute 45 a. m.

21. I hereby certify that I attended the deceased from August 8 1942 to August 9 1942
that I last saw him alive on August 9 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Arsenical Hepatitis

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Same as 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) (e) Means of injury

23. Signature G.P. Brown (M. D. or other)

Address Gen. Hosp. #2-600 E. 22 Date signed 8-11-42

(Licensed Embalmer's Statement on Reverse Side)

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

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

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.....

Isaac J. Manlove

Licensed Embalmer No.....

3994

P. O. Address.....

2503 Highland

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No. 1

Registrar's No. 3044

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(If outside city or town limits write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hosp. #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME *Ernest White*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *M* 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..... years

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

8. AGE: Years Months Days If less than one day
36

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

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

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

(b) Address.....

19. (a) *9/2/42* (b) *M. M. Crowe*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

(d) Street No. *2329 Tracy*
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month *Aug* day *9*
year *42* hour..... minute..... M.

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

Immediate cause of death *Arsenical hepatitis*

Due to *Arsenical Therapy for Lues*

Due to..... *36g*

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?
.....
(Specify type of place) Means of injury.....

23. Signature *J. C. Jones* (M. D. or other).....

Address *Gen. Hosp. #2-602622* Date signed *8-19-42*

SUPPLEMENTAL

S-23667

NO

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