

FILED SEP 16 1942
1949

State File No.
Registrar's No. 3364

Primary Registration District No. 1002

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 & location)
(d) Length of stay: In hospital or institution 2 days specify whether
In this community 2 months
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. 1624 GARFIELD
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME CYNTHIA JACKSON
(b) If veteran, name war no
(c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9 day 8
year 1942 hour 5 minut 50 A.M.

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife unk
(c) Age of husband or wife if alive 30 years
7. Birth date of deceased: 3 (Month) 30 (Day) 1884 (Year)

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

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>5</u>	<u>8</u>	hr. min.

Immediate cause of death: Acute gastritis
Acute hepatitis
Due to Cause undetermined
Pending further investigation
Other conditions: (Include pregnancy within 3 months of death)

9. Birthplace Georgia
(City, town, or county) (State or foreign country)
10. Usual occupation House work
11. Industry or business at home
12. Name Charlie Wooten
13. Birthplace Georgia
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

Major findings: 125 ft
Of operations
Of autopsy see above
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Alma Jackson
(b) Address 1624 Starfield
17. (a) General (b) Date thereof 9-12-42
(Funeral, cremation, or removal) (Month) (Day) (Year)
(c) Place of burial or interment West Lawn Mausoleum
18. (a) Signature of funeral director W. W. Jones
(b) Address 440 State St. Kansas City
19. (a) 9-12-42 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

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 W. W. Jones (M. D. or other) _____
Address K. C. Mo. Date signed 9/9/42

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 W. G. Flynn

Licensed Embalmer No. 2211

P. O. Address. 1819 E. 15th

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

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

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

1B
40
2559

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. Registrar's No. **3364**

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 Hospital #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.....

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Female** 5. Color or race **Negro** 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
58 hr. min.

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

10. Usual occupation.....

MOTHER FATHER

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

18. (a) Signature of funeral director..... (b) Address.....
19. (a) **9/12/42** (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..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month **Sept.** day **8th**
year **1942** hour **4:15** minute **A.** M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on **Coroner**..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute gastritis and hepatitis**

Due to **Time at Room**

Due to **--**

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) **suicide**

(b) Date of occurrence **9/6/42**

(c) Where did injury occur? **Kansas City, Missouri**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work? **no** (Specify type of place) **took rat**
(e) Means of injury **poison**

23. Signature **Crowe** **4/5/43**
Address **Hew** Date signed

SUPPLEMENTARY

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

29454