

S. No. 2
4-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5100

State File No. _____

Registration District No. 85 1943/9

Primary Registration District No. 1002

Registrar's No. 497

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 1-23-43-1-24-43
(Specify whether years, months or days)

In this community 20 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME LILLIAN CROW

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 widow

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 4 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>10</u>	<u>20</u>	hr. _____ min.

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

10. Usual occupation unemployed

11. Industry or business _____

MOTHER FATHER

12. Name John Speed

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

14. Maiden name Sallie Stevens

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-43
(Month) (Day) (Year)

(c) Place: burial or cremation Windsor Cemetery

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

(b) Address 2000 E. 12th St. B. C. Mo.

19. (a) 2-1-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

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. 2217 Wabash
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24
year 1943 hour 2:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from January 23, 1943 to January 24, 1943
that I last saw her alive on January 24, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to _____

Due to _____

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)

(e) Means of injury _____

23. Signature J. O. Stevens (M. D. or other) _____

Address Gen. Hosp #2-600 E. 22 Date signed 1-25-43

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

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 A. T. Moore

Licensed Embalmer No. 948

P. O. Address Kansas City Mo

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.