S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 5 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5290

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 788

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 12-19-42-2-10-43 (Specify whether years, months or days)

In this community 37 years

2. USUAL RESIDENCE OF DECEASED: 48

(a) State: Missouri (b) County: Jackson 3

(c) City or town: Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 1334 E. 11
(If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: CLARA KIRKWOOD (JOHNSON)

3. (b) If veteran, name war: —no

3. (c) Social Security No.: none

4. Sex: Female

5. Color or race: Negro 3

6. (a) Single, widowed, married, divorced: Widow 2

6. (b) Name of husband or wife: —unknown

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

7. Birth date of deceased: December (Month) 10 (Day) 1885 (Year)

8. AGE: Years 57 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace: Fort Scott (City, town, or county) Kansas (State or foreign country) 1

10. Usual occupation: unemployed

11. Industry or business:

FATHER 12. Name: Sam Vann

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

MOTHER 14. Maiden name: Irene Vann

15. Birthplace: unknown (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: 2-15-43 (Month) (Day) (Year)

(c) Place: burial or cremation: West Lawn

18. (a) Signature of funeral director: H. B. Moore

(b) Address: 1820 E. 18th St.

19. (a) 2-15-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 10 year 1943 hour 10:30 minute a. M.

21. I hereby certify that I attended the deceased from December 19, 1942 to February 10, 1943 that I last saw her alive on February 10, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lung Abscess (Vincent's Angina in origin)	
Due to: Carcinoma of Jaw	
Due to: 45 D	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: Same as above

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)

While at work? (e) Means of injury:

23. Signature: [illegible] (M. D. or other)

Address: City Hosp. #2 - 6008.22 Date signed 2-12-43

(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 me

H B Moore, Registered Apprentice No.

working under my personal supervision.

Signed H B Moore

Licensed Embalmer No. 2410

P. O. Address 1620 E 18th st

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.