

S. No. 2
-11-10-39
-5-17-39
-1 X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 29 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5430

State File No. _____
Registrar's No. 540

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kan City Mo
(c) Name of hospital or institution:
3200 knowledge /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
(Specify whether
in this community 66 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson ⁴⁸
(c) City or town Kan City Mo ⁸
(If outside city or town limits, write "RURAL")
(d) Street No. 2123 Summit
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME Quackenbush, Abraham
3. (b) If veteran, name war unknown 3. (c) Social Security No. None
4. Sex M 5. Color or race W
6. (a) Single, widowed, married, 2 divorced Widower
6. (b) Name of husband or wife Eliza 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 17 1854
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 30
year 1943 hour 9 minute 45 a M.
21. I hereby certify that I attended the deceased from 1-14-43
_____, 19____, to 1-20-43, 19____;
that I last saw him alive on 1-29-43, 19____,
and that death occurred on the date and hour stated above.

8. AGE: Years 88 Months 10 Days 13 If less than one day
hr. _____ min. _____

Immediate cause of death _____
Due to Atherosclerosis
Due to 97

9. Birthplace Wis (City, town, or county) (State or foreign country)
10. Usual occupation labor
11. Industry or business City Street Dept
12. Name Abe Quackenbush
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Jennie Bailey
(b) Address 2123 Summit
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 2/3/43
(Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cem
18. (a) Signature of funeral director Don Mayberry
(b) Address 2315 S. 1st
19. (a) 2-2-43 (Date received local registrar) (b) M. M. Crowe (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 M. Lawrence (M. D. or other)
Address 3200 knowledge Date signed 2-31-43

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.....

Roy E Snow

Licensed Embalmer No. *2560*

P. O. Address *12 C 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, above space should be left blank.