No. 2
11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

5557

State File No.

FILED FEB 27 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 752

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

**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: Little Sisters of the Poor 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs. 8 mo (Specify whether
In this community 3 Years 8 Months
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 48

(a) State Missouri (b) County Jackson 2

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

(d) Street No. 5331 Highland
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME LOUISE TRAVERS

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White 1

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife Unmarried

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

7. Birth date of deceased March (Month) 22 (Day) 1864 (Year)

8. AGE: Years 78 Months 10 Days 16 If less than one day ___ hr. ___ min.

9. Birthplace ___ (City, town, or county) Wisconsin 1 (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Thomas Travers
13. Birthplace Norecord (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Eliza Cooney
15. Birthplace No Record (City, town, or county) 9 (State or foreign country)

16. (a) Informant Sr. St. Phile
(b) Address 5331 Highland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12 1943 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Quirk and Robin Co.
(b) Address 20 West Linwood

19. (a) 2-12-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 8th year 1943 hour 11: minute 00 P.M.

21. I hereby certify that I attended the deceased from Jan 7, 1943 to Feb 8, 1943 that I last saw her alive on Feb 7, 1943 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | 6 hours |
| Due to Generalized Arteriosclerosis | years |
| Due to Cardiac decompensation | 1 month |
| Other conditions (Include pregnancy within 3 months of death) 9 | |

Major findings:
Of operations
Of autopsy no

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 John T Skinner (M. D. or other) MD
Address 1402 Bryant Bldg Date signed 2/9/43

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Harold Remy

Licensed Embalmer No. 4097

P. O. Address.....

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

**If this body is not embalmed, above space should be left blank.**