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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 9 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5589**
Registrar's No. **5966**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5405 Charlotte St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None** (Specify whether
In this community **27 Yrs.** (Specify whether
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. **5405 Charlotte St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Christine J. WHITE.**
(b) If veteran, name war **None** (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **February** day **23rd**,
year **1943** hour _____ minute _____ M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **May 20th, 1891**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **2/21/43**
_____ 19 _____ to **2/23/43** 19 _____
that I last saw her alive on **2/23/43** 19 _____
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
51 **9** **3** _____ hr. _____ min.

Immediate cause of death **metastatic carcinoma of the cervix**
Due to **carcinoma of cervix** 3 yr.
Due to **49a**

9. Birthplace **Everest Kansas /**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Other conditions _____
(Include pregnancy within 3 months of death)

MOTHER FATHER { 11. Industry or business _____
12. Name **Andrew Poull**
13. Birthplace **Lux Germany /**
(City, town, or county) (State or foreign country)
14. Maiden name **Antonias Kashka**
15. Birthplace **Australia /**
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy **no.**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. W.E. Strickler.**
(b) Address **5405 Charlotte St.**
17. (a) **Burial** (b) Date thereof **2/26/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary.**
18. (a) Signature of funeral director **Melody-McGilley.**
(b) Address **K. C. Mo.**
19. (a) **2-24-43** (b) **M. B. Brown**
(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 injury)
23. Signature **M. B. Brown** (M. D. or other) **M.D.**
Address **1123 1/2 9th St** Date signed **2/23/43**

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

Dr. J. H. Hobbs

MAR 10 1943

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.....
.....
Licensed Embalmer No. *2999*
P. O. Address..... *K C*

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

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