

S. No. 2
M-542
7-5-17-39
PI 1942

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13184

State File No. _____

FILED MAY 6 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1995

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: Wheatley Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 57 days
(Specify whether
In this community 5 days
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. 3400 Colorado St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles H. Grant

3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased 12 28 1937
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 | 3 | 26 | _____ hr. _____ min.

9. Birthplace K.C. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name Alex Grant

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

14. Maiden name Canada Grant

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

16. (a) Informant Canada Grant
(b) Address 3400 Colorado St.

17. (a) Burial (b) Date thereof 4-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn
18. (a) Signature of funeral director W. Jones
(b) Address 440 Stateland

19. (a) 4-28-48 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 24
year 1943 hour 4: P.M. minute _____ M.
21. I hereby certify that I attended the deceased from April 17
1943 to April 24, 1943

that I last saw him alive on April 24, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia 3 Day
Duration

Due to Whooping Cough 1 wk

Due to measles 35 2 wks

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) Manner of injury _____

23. Signature Eugene P. Chatham (M. D. or other)
Address 1731 Brooklyn Date signed 4-26-48

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

MOTHER FATHER

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 *Eugene English*
Licensed Embalmer No. *4105*
P. O. Address *440 State St. N.C.*

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.