

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. **2360**

Registration District No. **1002**

Primary Registration District No. **1002**

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:
General Hospital #2 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5/17/43-5/18/43**
 (Specify whether
22 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson 48**
 (c) City or town **Kansas City 3**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1109 Garfield (Rear) 8**
 (If rural, give location) **0**
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **MARTHA CALLOWAY**

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

4. Sex **Female 3** 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 **? unknown**
 (Month) (Day) (Year)

8. AGE: Years **43** Months _____ Days _____ If less than one day hr. _____ min.

9. Birthplace **Marshall Texas 1**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joe Calloway**
 13. Birthplace **Shreveport Louisiana**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mollie Anderson**
 15. Birthplace **Shreveport Louisiana**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
 (b) Address **General Hospital #2**

17. (a) **Removal** (burial, cremation, or removal) (b) Date thereof **5-24-43**
 (Month) (Day) (Year)

(c) Place: burial or cremation **Westbury**
 18. (a) Signature of funeral director **Mrs. J. W. Jones**

(b) Address **440 State Ave. B. City**

19. (a) **5-24-43** (Date received local registrar) (b) **M. W. B. Stee** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **18**
 year **1943**, hour **6** minute **00** P.M.

21. I hereby certify that I attended the deceased from **May 17 43** to **May 18 43**
 that I last saw her alive on **May 18 1943**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Abdomen** (Cause Unknown)
 Duration _____

Due to **Acute Peritonitis**
 Due to **Causa Unknown**

Other conditions (Include pregnancy within 3 months of death) **129**

Major findings: Of operations _____
 Of autopsy _____
 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?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature **J. Calloway** (M.D. number) _____
 Address **Gen Hosp #2-600 E. 22nd St** Date signed **5-19-43**

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.....

P. O. Address.....

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.