S. No. 2
M—9-4-41
5-17-39
P I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16891

FILED JUN 7 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2058

1. PLACE OF DEATH:

(a) County Jackson County

(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: K.C. TBC. Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One month. In this community 3 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

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

(d) Street No. 1301 Woodland Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ruby McNeal Dean

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex F

5. Color or race Negro

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

6. (b) Name of husband or wife Leon Dean, Leon

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased May 18 1918 (Month) (Day) (Year)

8. AGE: Years 24 Months 11 Days 13 If less than one day hr. min.

9. Birthplace Tulsa (City, town, or county) OKla. (State or foreign country)

10. Usual occupation unemployed

11. Industry or business

FATHER 12. Name George McNeal

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

MOTHER 14. Maiden name Lucinda Robinson

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

16. (a) Informant Records K.C. Tbc Hosp

(b) Address K.C. MO.

17. (a) Interment (Burial, cremation, or removal) (b) Date thereof 5/3/43. (Month) (Day) (Year)

(c) Place: burial or cremation Muskogee Okla

18. (a) Signature of funeral director Williams Funeral Home

(b) Address 1729 Lydia

19. (a) 5-3-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st year 1943 hour 4:00 minute 45 A.M.

21. I hereby certify that I attended the deceased from 2-9-43 to 5-1-43, 19..., to ..., 19... that I last saw him alive on 5-1-43, 19... and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary tuberculosis	1yr
Due to Tuberculous meningitis	--
Due to	--
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.

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 0

23. Signature William T. Safford M.D.

Address K.C. Tbc Hosp Date signed 5-1-43

(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.....

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.