

JUN 30 1943

149

Primary Registration District No. 1002

Registrar's No. 2721

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:
4615 Jarboe Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---
(Specify whether

In this community 35 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

(c) City or town Kansas City ⁵
(If outside city or town limits, write "RURAL")

(d) Street No. 4615 Jarboe Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country --- ⁰

3. (a) PRINT FULL NAME Mrs. Daisy Aldean Ginette

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband Mr. Wilford Ernest Ginette

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

7. Birth date of deceased June 14 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	0	0	hr. min.

9. Birthplace Longton Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business ---

12. Name Emory J. Sweet

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

14. Maiden name Katherine Marble

15. Birthplace Syracuse New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marguerite Ginette Boyer

(b) Address 4615 Jarboe

17. (a) Burial (b) Date thereof June 16, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Newcome's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 6-16-43 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th
year 1943 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1941 to June 14, 1943
that I last saw he alive on June 12, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation ^{Duration 2 weeks}

Due to Chronic Myocarditis

Due to Arthritis

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

Major findings: Arthritis

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. James Brinson (M.D. or other) D.O.

Address 615 Bryant Bldg Date signed 6-16-43

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

MOTHER FATHER

724 Blue

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.....

H. H. Newcomer Jr.

Licensed Embalmer No.....

4043

P. O. Address.....

H. H. Newcomer Jr.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. JUL
Registrar's No. 272/

Registration District No. 149 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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days (Specify whether _____)
3. (a) PRINT FULL NAME Daisy A. Linette
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 14 (Month) (Day) (Year)
8. AGE: Years 64 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace (City, town, or county) _____ (State or foreign country) _____
14. Maiden name _____
15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decon- sultation Duration _____
Due to Chronic myocarditis
Due to _____

Other conditions Tuberculosis of lungs (include pregnancy within 3 months of death)
Major findings: adiposities
Of operations _____
Of autopsy 13 p 1

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 _____ (M. D. or other)
Address _____ Date signed _____

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