

7. S. No. 2
M-9-4-41
5-17-38
PI X2948

20446

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **2781**

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 Mo**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Research hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 weeks**.
(Specify whether years, months or days)

In this community **2 wks**.

2. USUAL RESIDENCE OF DECEASED **Lafayette**

(a) State **Missouri** (b) County **Jackson**

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Guy M. Kendall**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **M**

5. Color or race **white**

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

6. (b) Name of husband or wife **Ann Keedes**

6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Nov. 24 1877**
(Month) (Day) (Year)

8. AGE: Years **65** Months **6** Days **27**
If less than one day _____ hr. _____ min.

9. Birthplace **Maule Rock down 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Physician**

11. Industry or business _____

12. Name **John P. Kendall**

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

14. Maiden name **Clarke Munford**

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

16. (a) Informant **Guy M. Kendall**

(b) Address **Corder Mo.**

17. (a) **Burial** (b) Date thereof **6-19-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Burial W. Wrensbury, Mo.**

18. (a) Signature of funeral director **W. H. Brown**

(b) Address **Higginsville, Mo.**
6-21-43 (c) **W. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **16**
year **1943** hour **9** minute **9** M.

21: I hereby certify that I attended the deceased from **6-1-43** to **6-16-43** 19____
that I last saw him alive on **6-16-43** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal Obstruction** Duration **20 hrs**

Due to **Carcinoma Spleen flexure colon** **17 hr**

Due to **He 2**

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

PHYSICIAN

Major findings: **Carcinoma, Obstruction**

Of operations _____

Of autopsy **no**

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)

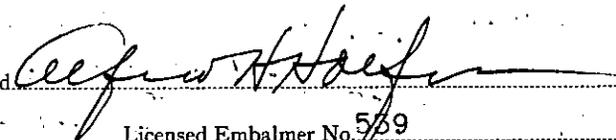
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **W. E. Brown** (M.D. or other) _____
Address **W. E. Brown** Date signed _____

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.....

..... Forrest A. Hoefler Registered Apprentice No. 336
working under my personal supervision.

Signed .....

Licensed Embalmer No. 569.....

P. O. Address Higginsville. Mo......

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.