

No. 2
1-4-41
17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20824**
Registrar's No. **609**

FILED JUN 29 1943

Registration District No. **35 42**

Primary Registration District No. **1001 1000**

1. PLACE OF DEATH:
BUCHANAN
(a) County
ST. JOSEPH
(b) City or town
(c) Name of hospital or institution: **State Hospital # 22**
(d) Length of stay: In hospital or institution **3 1/2 days**
In this community **4 yrs**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Jackson**
(c) City or town **Kansas City Mo**
(d) Street No. **3027 Michigan Ave**
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **Lillian Dates**
3. (b) If veteran, name war
3. (c) Social Security No. **nil**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7/16** day
year **1943** hour **8** minute **10 a.m.**
21. I hereby certify that I attended the deceased from **Jun 15 1942 to May 16 1943**
that I last saw him alive on **May 15 1943**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **not given**
6. (c) Age of husband or wife if alive _____ years

Immediate cause of death **chronic endocarditis of aortic**
Due to **arteriosclerosis insignificant time**
Other conditions **922**
(Include pregnancy within 3 months of death)

8. AGE: Years **68** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **housewife**

11. Industry or business **at home**

12. Name _____
13. Birthplace **Canada** (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace **England** (City, town, or county) (State or foreign country)

16. (a) Informant **Hospital record**
(b) Address **State Hospital # 2**

17. (a) **removed** (b) Date thereof **7/16 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kansas City Mo**

18. (a) Signature of funeral director **Bylan Funeral Home**
(b) Address **1800 Lindwood Ave. Mo**

19. (a) **5-16-43** (b) **Rose Herzog**
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Major findings:
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 **O. E. Jones** (M. D. of other) _____
Address **State Hospital # 2** Date signed **7/16 1943**

(Licensed Embalmer's Statement on Reverse Side)

St. Joseph, Mo.

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

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..... *Chas Wilks*.....
Licensed Embalmer No. *2644*
P. O. Address..... *1800 Pinewood*.....

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.