

S. No. 2
DM-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30586

State File No. 4108

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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:
Lake Side Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether)

In this community 5 days
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") ⁸

(d) Street No. 3114 Indiana
(If rural, give location)

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

3. (a) PRINT FULL NAME Rary Ray Adkins

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1943 hour 1 minute 30.0 M.

4. Sex Male 5. Color or race White

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 Sept 19-1943
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 19th 1943 to Sept. 20 1943
that I last saw him alive on Sept. 23 1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

0 0 5 _____ hr. _____ min.

9. Birthplace K.C. Mo
(City, town, or county) (State or foreign country)

Immediate cause of death: Respiratory failure

Due to prematurity

Due to cellulitis mother

Other conditions none
(Include pregnancy within 3 months of death)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name W. Adkins

13. Birthplace mo. O
(City, town, or county) (State or foreign country)

14. Maiden name Helen Kelly

15. Birthplace mo. O
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: ✓

Of operations _____

Of autopsy ✓

16. (a) Informant W. Adkins

(b) Address 3114 Indiana

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof Sept. 27 43
(Month) (Day) (Year)

(c) Place: burial or cremation Bethany mo

18. (a) Signature of funeral director W. C. Porter

(b) Address 918 Brooklyn

19. (a) 9-27-43 (Date received local registrar)

(b) J. E. Brown (Registrar's signature)

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 V. H. Harrell (M. D. or other) DO

Address 406 W. Wacker Drive Date signed 9-25-43

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

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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.