

V. S. No. 2
FORM-2-43
Rev. 5-17-39
X13597

30568

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 21 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3863

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3334 Agnes Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Beatrice Cummings

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unknown
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business unknown

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant K. C. General Hospital

(b) Address K. C. Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 8, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Mo

18. (a) Signature of funeral director J. J. ...

(b) Address St Joseph Mo

19. (a) 9-8-43 (Date received local registrar) (b) W. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5th
year 1943 hour 4 minute 45 A.M. M.

21. I hereby certify that I attended the deceased from September 4 1943, to September 5th 1943; that I last saw her alive on September 5th 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction; Hypertrophy & dilatation of heart; Chronic vascular nephritis

Due to _____
Due to 131a

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? _____

While at work _____ (Specify type of place) Means of injury _____
23. Signature Wm. R. Thom (M. D. or other) 9-8-1943
Address Med. Mt. K. C. General Hospital Date signed _____

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

MOTHER FATHER

SEP 27 1943

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..... *Roy E Snow*
Licensed Embalmer No..... *2560*
P. O. Address..... *KC 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.