

B. No. 2
M-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31783**
Registrar's No. **202**

Primary Registration District No. **3026**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Independence**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1016 South Woodland Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **--**
In this community **29 Years** (Specify whether 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. **4604 Tracy Avenue**
(If rural, give location)
(e) Citizen of foreign country? **-- No** (Yes or No)
If yes, name country **--**

3. (a) PRINT FULL NAME **Mrs. Lorena Tecklaw Hurt**
(b) If veteran, name war **No**
(c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **1st**
year **1943** hour **4** minute **20 P.** M.
21. I hereby certify that I attended the deceased from **Nov 10**, 19**43** to **Aug 1**, 19**43**
that I last saw her alive on **July 26**, 19**43**
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**
(b) Name of husband or wife **Mr. Warren Hurt**
(c) Age of husband or wife if alive **55** years
7. Birth date of deceased: **February 4 1889**
(Month) (Day) (Year)

Immediate cause of death **Causes of uterus**
Duration **1 yr.**

8. AGE: Years Months Days If less than one day
54 5 27 hr. min.

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

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

10. Usual occupation **Housewife**

11. Industry or business **--**

MOTHER FATHER
12. Name **Archibald Ice**
13. Birthplace **Unknown Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary E. Fagert**
15. Birthplace **Unknown Ohio**
(City, town, or county) (State or foreign country)

Major findings: **Abscess of pelvis**
Of operations _____
Of autopsy **HJP**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mr. Warren Hurt**
(b) Address **4604 Tracy Avenue, K. C. Mo.**

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? **Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 3, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of cremation **Forest Hill Cemetery, K. C. Mo.**

18. (a) Signature of funeral director **D. W. Newcomer's Sons**
(b) Address **1401 Brush Creek Blvd. K.C. Mo.**

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature **DR. EDWARD H. SKINNER** (M. D. or other)
Address _____ Date signed **8/2/43**

19. (a) **8-2-1943** (b) **James W. Ross**
(Date received legal control) (Registrar's signature)

JAN 2 01944

1532 Professional Bldg.
10.4

OCT 10 1944

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. C. Newcomer Jr.*

Licensed Embalmer No..... *4043*

P. O. Address..... *H. C. 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.