

No. 2
4-2-43
1-17-39
FILED

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33835

NOV 1 1943

149

Registration District No.

1002

State File No.

Registrar's No.

4413

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. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community 13 years
years, months or days (Specify whether)

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. 607 1/2 Main
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph Jarrett

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed 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: April 15 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 45 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Stationery Engineering

11. Industry or business _____

12. Name John Jarrett

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

14. Maiden name Sarah Huff

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

16. (a) Informant Record Clerk

(b) Address Gen'l Hosp.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-18-43
(Month) (Day) (Year)

(c) Place: burial or cremation Lead

18. (a) Signature of funeral director John A. Johnson

(b) Address City Stationer

19. (a) 10-18-43 (Date received local registrar) J. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30th
year 1943 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from Sept. 24th 43 to Sept. 30th 43
that I last saw him alive on Sept. 30th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious Anemia Duration _____

Due to 73a

Due to _____

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 Dr. R. Thom (M.D. or other) 10-1-43

Address Med. Dir. Gen'l Hosp. Date signed 10-1-43

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

MOTHER FATHER

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.