

S. No. 2  
M-9-4-41  
5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33868

State File No. \_\_\_\_\_

FILED NOV 1 1943 149

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 4506

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

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: R. C. TB Hosp. O  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 m 6d. (Specify whether 29 yrs.)

In this community \_\_\_\_\_ 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. 2818 Cherry  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles McDonald

3. (b) If veteran, name war no

3. (c) Social Security No. 496-09-5476

4. Sex m 5. Color or race W

6. (a) Single, widowed, married, divorced sep. 7

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 8 13 1904  
(Month) (Day) (Year)

8. AGE: Years 39 Months 2 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas City Mo. O  
(City, town, or county) (State or foreign country)

10. Usual occupation Telegraph Dispatcher

11. Industry or business \_\_\_\_\_

12. Name John McDonald

13. Birthplace Louisville Ky. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Florence Clay

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

16. (a) Informant Reeds K.C. TB Hosp

(b) Address Reeds Mo

17. (a) Buried (b) Date thereof 10-23-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys

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

(b) Address R. C. Mo

19. (a) 10-23-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 20  
year 1943 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from 9-14-43  
\_\_\_\_\_ 19 \_\_\_\_\_ to 10-20 19 43  
that I last saw h. l. m. alive on 10-20 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 1y 4m

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions T.B. Langgish; T.B. Entenks 138  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy same

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)

(e) Means of injury \_\_\_\_\_

23. Signature Matthew J. Noon (M. D. or cross)

Address Reeds Mo Date signed 10/24/43

Quirk + Tobin  
Main & Lenoxwood

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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.**