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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 5 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41062

State File No. \_\_\_\_\_  
Registrar's No. **5324**

Registration District No. 149 Primary Registration District No. 1002

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. Gen'l Hosp. No. 10  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether  
In this community unknown  
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. 555 1/2 Main  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Maynard Irick

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

4. Sex male 5. Color or race w 6. (a) Single, widowed, married, divorced unk

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

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

8. AGE: Years app. 40 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Quirk & Proben

(b) Address K.C. Mo.

17. (a) Removal Removal (b) Date thereof 12-20-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence Hans Miss. Hosp.

18. (a) Signature of funeral director Quirk & Proben

(b) Address K.C. Mo.

19. (a) 12-16-43 (b) P. C. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 13  
year 1943 hour 3 minute 20A M.

21. I hereby certify that I attended the deceased from December 9 1943 to December 13 1943  
that I last saw him alive on December 13 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Malignant hyper-tension-Malignancy of lower bowel Duration

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

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)

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

23. Signature Clark W. Seely MD (M. D. or other) \_\_\_\_\_

Address General Hospital Date signed 12/13/43

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

MOTHER FATHER

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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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *Jan*

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

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

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Jackson*  
 (b) City or town *Kennett*  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
*K.C. General Hosp.*  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME *Magnard Trick*

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex *m* 5. Color or race *w*

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

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years *40* Months \_\_\_\_\_ Days \_\_\_\_\_  
(if less than one day hr. min.)

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* Day *18*  
 year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

*alignant hyper-tension, lower bronchitis*  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: *Adeno carcinoma of rectum*  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
 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) Month of injury \_\_\_\_\_

23. Signature *Clark W Sedy M.D.* (M. D. or other)

Address *Genl Hospital* Date signed \_\_\_\_\_

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

SUPPLEMENTAL

S-41063