

41224

No. 2
-2-43
-17-39
X35957

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 3 1944
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5379

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: 4230 Tracy /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX
In this community 2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

(c) City or town Kansas City ³
(If outside city or town limits, write "RURAL")

(d) Street No. 4230 Tracy ⁸
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) ¹
If yes, name country _____

3. (a) PRINT FULL NAME MRS. LOTTIE POPE

3. (b) If veteran, name war XX

3. (c) Social Security No. No

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Alfred Pope

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

7. Birth date of deceased August 16 1853
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>90</u>	<u>4</u>	<u>2</u>	<u>hr. min.</u>

9. Birthplace London Canada ²
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Ernest Forbes

13. Birthplace Canada ²
(City, town, or county) (State or foreign country)

14. Maiden name Charlotta Keirsteadt

15. Birthplace Canada ²
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mabel Chamberlain

(b) Address 4230 Tracy

17. (a) (Burial, cremation, or removal) Removal

(b) Date thereof 12-19-43
(Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Illinois

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

(b) Address Kansas City, Mo.

19. (a) 12-18-43 (Date received local registrar)

(b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
year 1943 hour 12: minute 20 A. M.

21. I hereby certify that I attended the deceased from Dec. 15 1943 to Dec. 18 1943
that I last saw her alive on Dec. 18 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Cerebral hemorrhage ^{3 days}

Due to _____

Other conditions Myocarditis ^{6 yr.}
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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)

(a) Means of injury 2

23. Signature A. Herman Shablin (M. D. or other) ¹⁰⁰

Address 3208 Independence Date signed 12-18-43

Duration 10 hrs.

3 days

6 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2108
BF 2766

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 A. R. Haenschel

Licensed Embalmer No. 4159

P. O. Address A. C. 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____

Primary Registration District No. 11

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town J.R.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 24 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Lothie Pope
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 2 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased any 16 1943
(Month) (Day) (Year)

8. AGE: Years 90 Months 4 Days _____ (less than one day)
hr. min.

9. Birthplace Canada
(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

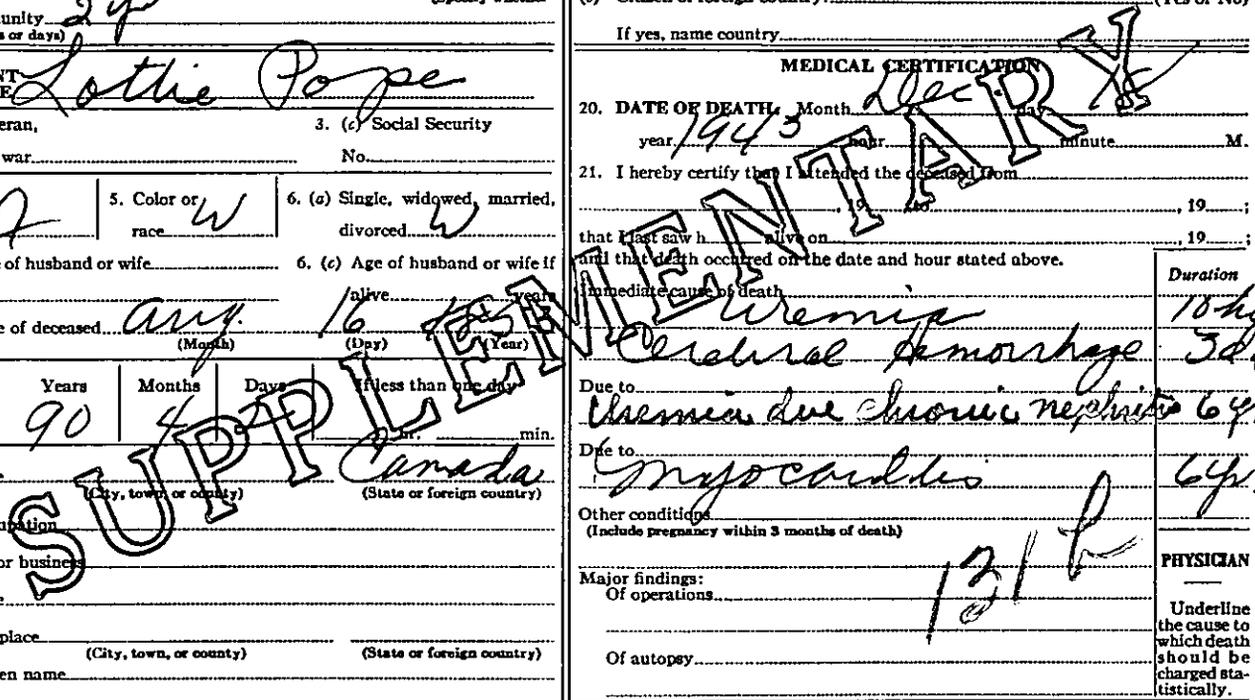
20. DATE OF DEATH: Month Dec Day 13 Year 1943 hour _____ minute _____ M.

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 _____

Myocardial infarction
Cholesterol thrombosis
Due to Uremia due chronic nephritis 6 yrs.
Due to myocarditis 6 yrs.
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____



MOTHER FATHER

S-41224