

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 17 1943

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 143

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Rural Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County Emergency Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community 37 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Lees Summit Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Unity Ridge
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Emma White

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 1 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 6 9 _____ hr. _____ min.

9. Birthplace New St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown Stites
13. Birthplace Unknown Pennsylvania
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Childers
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ida White

(b) Address Box 6814 Parkway Station K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11 - 43
(Month) (Day) (Year)

(c) Place: burial or cremation Newcomer's Vault B.C. Mo

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address Kansas City, Missouri

19. (a) Nov 10, 1943 (Data received local registrar) (b) F. M. Schiele D. G. Schiele (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9
year 1943 hour 10 minute 50 a.m.

21. I hereby certify that I attended the deceased from 11-2 1943 to 11-9 1943
that I last saw h. er alive on 11-9 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia 3da
fractured rib
Due to _____

Other conditions: 186a
(Include pregnancy within 3 months of death)

Major findings: 186a
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 1048

(b) Date of occurrence 11-2-43

(c) Where did injury occur W.D. Keenan Jr. Res
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home
While at work? Yes (Specify type of place) (e) Means of injury fell

23. Signature [Signature] (M. D. or other)

Address [Signature] Date signed 11/10/43

Duration
3da
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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. *40403*

P. O. Address *H. 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.