

FILED FEB 28 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1776**
Registrar's No. **33**

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. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether
In this community **7 yrs -**
years, months or days)

3. (a) PRINT FULL NAME **Johanne Talbot**

3. (b) If veteran, name war **no** 3. (c) Social Security No. _____

4. Sex **Fe** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **no**
6. (b) Name of husband or wife **Chris Talbot** 6. (c) Age of husband or wife if alive **63** years
7. Birth date of deceased **Mar - 27 1884**
(Month) (Day) (Year)

8. AGE: Years **59** Months **9** Days **4** If less than one day hr. min.

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

10. Usual occupation **Newsreader**

11. Industry or business _____

MOTHER FATHER
12. Name **Andrew Anderson**
13. Birthplace **Denmark**
(City, town, or county) (State or foreign country)
14. Maiden name **See Record**
15. Birthplace **Denmark**
(City, town, or county) (State or foreign country)

16. (a) Informant **Chris Talbot**
(b) Address **921 Paseo**

17. (a) **Burial** (b) Date thereof **Jan 5 - 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **Miss C. R. Foster**

(b) Address **914 Madison**

19. (a) **Jan 4 1944** (b) **J. E. Brown**
(Date received local registrar) (Registrar's signature)

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. **921 Paseo**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **3**
year **1944** hour **11** minute **5 A.** M.

21. I hereby certify that I attended the deceased from **January 2 1944** to **January 3 1944**
that I last saw her alive on **January 3 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Cardiovascular disease**

Due to _____
Due to **932**

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy **See above**
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 **A. E. Upsher** (M. D. or other) **J. M. W.**
Address **Med. Dir. Gen'l Hosp.** Date signed **1-4-44**

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

Daniel E. Browning

Licensed Embalmer No. *2724*

P. O. Address *H. E. 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.