

U. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

6139

FILED FEB 24 1944

Registrar's No.

640

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:  
General Hospital No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-26-44-2-6-44  
(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. 204 Waldo  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME CARRIE ISRAEL

3. (b) If veteran, name war NO 3. (c) Social Security No. 492-18-0073

4. Sex Female 5. Color or Race Negro 6. (a) Single, widowed, married, divorced Separate  
6. (b) Name of husband or wife James Israel 6. (c) Age of husband or wife if alive 44 years  
7. Birth date of deceased March 3 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
51 11 3 hr. min.

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

10. Usual occupation Unemployed

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

MOTHER FATHER { 12. Name John Smith  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Ann Moore 9  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 2-10-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Home

18. (a) Signature of funeral director C. E. Davis

(b) Address Independence, Mo.

19. (a) 2-8-44 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 6  
year 1944 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from January 26  
1944 to February 6, 1944;  
that I last saw her alive on February 6, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia  
Lobular

Due to Congestive heart failure

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

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)  
Means of injury fall

23. Signature D. E. Brown (M. D. or other)  
Address Gen. Hosp. #2 608 E 22 Date signed 2/8/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

L. J. Harris Sr.  
Licensed Embalmer No. 3388

P. O. Address W. E. Moo

**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.**