

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6237  
602  
Registrar's No. \_\_\_\_\_

FILED FEB 18 1944  
Registration District No. 749

Primary Registration District No. 1002

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

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: Menorah Hospital, 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution since Monday 1-30-44 - 2-4-44  
(Specify whether  
In this community since 1904  
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. 6425 Morningside Drive  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_ X

3. (a) PRINT FULL NAME Jacob A. Mott

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mrs. Bertha Mott 6. (c) Age of husband or wife if alive unknown years  
7. Birth date of deceased December 10 1875  
(Month) (Day) (Year)

8. AGE: Years 68 Months 1 Days 24 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Optometrist

11. Industry or business X

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

16. (a) Informant Mrs. Fred Cooper  
(b) Address 6425 Morningside Drive, K.C., Mo.  
17. (a) Burial (b) Date thereof 2-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Stine & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 2-5-44 (b) T. E. Brown  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 4  
1944 year hour \_\_\_\_\_ minute P M.

21. I hereby certify that I attended the deceased from 1/30/44 to 2/4/44  
that I last saw him alive on 2/4/44 and that death occurred on the date and hour stated above.

Immediate cause of death Infection of urinary tract (Typhoid)  
stricture of urethra  
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)  
(c) Means of injury \_\_\_\_\_  
23. Signature J. B. Williams (M. D. or other)  
Address 424 1/2 1st St. Smith Date signed 2/4/44

Dr. Clinton Smith and  
Bohart Uhlman

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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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. 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.**