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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13681

State File No. ....

Registrar's No. 1928

FILED MAY 11 1944  
Registration District No. 1999

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:  
K. C. General Hospital No. 18  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days  
(Specify whether)

In this community 3 mo  
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. 2334 Holly  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Felope Gonzalez

3. (b) If veteran, name war WW

3. (c) Social Security No. none

4. Sex Male

5. Color or race Mexican

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

6. (b) Name of husband or wife

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

7. Birth date of deceased January 11 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 21 23 hr. min.

9. Birthplace Kansas City MO  
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business

12. Name Raphael Gonzales

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

14. Maiden name Rafael Ramirez

15. Birthplace Chanute Kansas  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Raphael Gonzales

(b) Address 2334 Holly KC MO

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

(b) Date thereof 5-6-44  
(Month) (Day) (Year)

(c) Place: Burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Blaine E. Willett

(b) Address 2332 Monitor Place

19. (a) 5-6-44 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th  
year 1944 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 29, 1944 to May 4, 1944;  
that I last saw him alive on May 4, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Confluent broncho-pneumonia-Septicemia ✓

Duration

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy See above

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)

(a) Means of injury 0

23. Signature A. E. Usher (M.D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 5-5-44

**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 *Jack W. Laybourn*  
Licensed Embalmer No. *1715*  
P.O. Address *K. 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1978

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(c) Name of hospital or institution:  
General Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME

Rolpe Gonzalez

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

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

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

9. Birthplace..... (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 5/16/1944 (Date received local registrar) (b) T. E. Brown (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) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... month..... day.....  
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Confluent Broncho  
Pneumonia  
Septicemia

Due to.....

Due to.....  
hemolytic staphylo-  
cococcus aureus -

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

Major findings: Of operations.....

Of autopsy: proven by 107 culture.

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.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

13681