

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 5 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13766
Registrar's No. 1816

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 3-17-44-4-24-44
(Specify whether years, months or days)
In this community 40 years

3. (a) PRINT FULL NAME CHARLIE A. McNARY
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 9 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 10 15 hr. min.

9. Birthplace Nashville Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name James McNary

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

14. Maiden name Martha ?

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Removal (b) Date thereof 4-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Banner Spgs Mo

18. (a) Signature of funeral director Sturmon F. How

(b) Address N. C. Kansas

19. (a) 4-25-44 (b) N. 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. 1607 Lydia
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1944 hour 2:23 minute 4 M.

21. I hereby certify that I attended the deceased from March 17
1944, to April 24, 1944;
that I last saw him alive on April 24, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Congestive Failure

Due to Hypertensive type heart disease

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?

(e) Means of injury _____

23. Signature J. A. Turner (M. D. or other)

Address Quincy Mo. #2 6086 22 Date signed 4/25/44

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

PHYSICIAN

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.....

Licensed Embalmer No.....

P. O. Address.....

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, it should be so stated above.