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K37823

FILED MAY 25 1944

Registration District No. 199

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 mo. 2 days  
(Specify whether  
In this community 20 yr  
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")  
2215 Bales  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country

3. (a) PRINT FULL NAME Sanford Jeffries

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 Martha Jeffries 6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased July 22, 1865  
(Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days 23 If less than one day  
hr. min.

9. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Blacksmith

11. Industry or business Retired

12. Name Matt Jeffries

13. Birthplace Mo 0  
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie Albert

(b) Address 2209 Bales

17. (a) Burial (b) Date of death May 20-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Wm C R Gantner

(b) Address 918 Brooklyn

19. (a) May 18, 1944 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15  
year 1944 hour 2 minute 50 P.M.

21. I hereby certify that I attended the deceased from April 13, 1944 to May 15, 1944  
that I last saw him alive on May 15, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus septicemia ✓  
Duration

Due to Supp 5/18  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy None  
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 no  
23. Signature A. E. Usher (M. D. or other) M.D.  
Address Med. Dir. Gen'l Hosp. Date signed 5-16-44

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

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, 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. 2146

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... (If outside city or town limits, write "RURAL" and name of township)  
(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: Sanford Jfferes

3. (b) If veteran, name war..... 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 78 Months Days If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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)..... (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (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 May day 15  
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....  
that I last saw h..... alive on.....  
and that death occurred on the date and hour stated above.

Immediate cause of death: hemolytic streptococcus septicemia

Due to.....

Due to..... primary origin not known - probably lung

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

No injuries

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) (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.

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

17055