

S. No. 2
OM-5-43
ev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30060

State File No. _____

FILED OCT 2 1944 49

Primary Registration District No. 1002

Registrar's No. 3807

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

33580

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: Menorah Hosp;
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hr. 0
(Specify whether)

In this community 4 yrs.
years, months or days

3. (a) PRINT FULL NAME Robert C. Dalton

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male 0 5. Color or race white 0

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased April 23 1940
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>4</u>	<u>4</u>	<u>21</u>	_____ hr. _____ min.

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

10. Usual occupation child

11. Industry or business _____

12. Name Leroy Dalton

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

14. Maiden name Ruby Luse

15. Birthplace Johnson Co., Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Ruby Dalton Feighner

(b) Address 825 Packard

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

(b) Date thereof 9-15-44
(Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill, K. C.

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

(b) Address K. C. Kans.

19. (a) 9-21-44 (Date received local registrar)

(b) N. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte 99

(c) City or town Kansas City 14
(If outside city or town limits, write "RURAL")

(d) Street No. 825 Packard
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14
year 1944 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept. 13, 1944 to Sept. 14, 1944

that I last saw him alive on 3:00 A.M. 9-14-, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Purpura Hemorrhagica. Duration _____

Due to _____

Due to _____ 72 a

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature [Signature] M. D. or other _____
Address 4712 1/2 E. 25th Date signed 9/20/44

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.....

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.