S. No. 2
M—8-43
5-17:39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30339

FILED SEP 26 1944

Registration District No. 177

Primary Registration District No. 1002

Registrar's No. 3682

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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-5-44-8-29-44 (Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1104 Park 2
(If rural, give location)

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

3. (a) PRINT FULL NAME JIM TRICE

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widower 2

6. (b) Name of husband or wife unk

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

7. Birth date of deceased September (Month) 28 (Day) 1889 (Year)

8. AGE:

Years	Months	Days	If less than one day
55	11	1	hr. min.

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

10. Usual occupation Unemployed

11. Industry or business ✓

FATHER
12. Name DONT KNOW
13. Birthplace DONT KNOW (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name DONT KNOW
15. Birthplace DONT KNOW (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address Gen. Hosp. #2

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-12-44 (Month) (Day) (Year)
(c) Place: burial or cremation HIGHLAND

18. (a) Signature of funeral director Flynn & Green Street
(b) Address 1819 E. 15th K.C. Mo

19. (a) 9-11-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29
year 1944 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from June 5, 1944 to August 29, 1944;
that I last saw him alive on August 29, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac TAMPONADE

Due to Pericardial effusion

Due to Decompensation

Other conditions
(Include pregnancy within 3 months of death)

95 C

Major findings:
Of operations

Of autopsy

Duration

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 0

23. Signature [signature] (M. D. or other)
Address Gen. Hosp. #2 600 E. 22nd Date signed 8-31-44

(Licensed Embalmer's Statement on Reverse Side)

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. 4383

P. O. Address 1819 E. 15th KCMo

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.