

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38756

State File No. _____

FILED DEC 9 1944

Registration District No. _____

Primary Registration District No. _____

1002

Registrar's No. 4837

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: Kansas City Osteopathic Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14 hours
(Specify whether
 In this community life 0
years, months or days)

3. (a) PRINT FULL NAME Carol Jane Hendrix3. (b) If veteran, name war. no 3. (c) Social Security No. none4. Sex Female 5. Color or race White 6. (a) 0 Single, widowed, married, divorced Child

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

7. Birth date of deceased September 13, 1935
(Month) (Day) (Year)8. AGE: Years 9 Months 2 Days 15 If less than one day hr. _____ min. _____9. Birthplace Independence, Missouri
(City, town, or county) (State or foreign country)10. Usual occupation schoolgirl

11. Industry or business _____

12. Name Harvey O. Hendrix13. Birthplace St. Joseph, Missouri
(City, town, or county) (State or foreign country)14. Maiden name Patty Ryttegrove15. Birthplace Independence, Missouri
(City, town, or county) (State or foreign country)16. (a) Informant Mr. Harvey Hendrix(b) Address Independence, Mo.17. (a) Burial (b) Date thereof 12-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mound Lane Cem.18. (a) Signature of funeral director Robert R. Speake(b) Address Independence, Mo.19. (a) 12-1-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Rural Blue
(If outside city or town limits, write "RURAL")
 (d) Street No. King Hwy # Judfall
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28
 year 1944 hour 10 minute 50 P.M.21. I hereby certify that I attended the deceased from Nov. 27 1944 to Nov 28 1944;
 that I last saw her alive on November 28 1944;
 and that death occurred on the date and hour stated above.Immediate cause of death Lobar Pneumonia Duration 2 days

Due to ?

Due to ?

Other conditions 108
(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? _____

While at work? _____
(Specify type of place) (e) Means of injury23. Signature Dred J. Zammer (M. D. or other) D.O.Address Independence, Mo. Date signed 11-30-44

(Licensed Embalmer's Statement on Reverse Side)

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

48
3
8

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Roland P. Speaks*.....
Licensed Embalmer No. *3604*.....
P. O. Address *Independence, 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.