

S. No. 2
M-2-43
5-17-39
X3567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40004

State File No. _____

FILED JAN 11 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5322

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

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. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day 8 1/2 hrs.
 In this community 57 1 (Specify whether 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")
 (d) Street No. 7021 E. 12 Terr.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Effie Brents

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Fred 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased May 23, 1887
 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28
 year 1944 hour 12 minute 50 A. M.
 21. I hereby certify that I attended the deceased from Dec. 26 1944 to Dec. 28 1944
 that I last saw her alive on Dec. 28 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident Duration _____

8. AGE: Years 57 Months 7 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business None

12. Name Geo. Porter

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

14. Maiden name Unknown

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

16. (a) Informant Fred Brents

(b) Address 7021 E. 12th Terr

17. (a) _____ (b) Date thereof 12-30-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director G. H. Blackman, Sr.

(b) Address R. E. No.

19. (a) 12-29-44 (b) D. E. Brown
 (Date received local registrar) (Registrar's signature)

Due to _____
 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) (e) Manner of injury _____

23. Signature A. E. Washer (M. D. of _____)
 Address Med. Dir. Gen'l Hosp Date signed 12-28-44

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.