

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40168

FILED DEC 22 1944

State File No. _____

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 5075

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 #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12-9-44 7 hrs. 50 Min.
(Specify whether years, months or days) 2 years

In this community _____
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. 2410 Wabash
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME JESSICA HOUSE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: September 25 1942
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9
year 1944 hour 9:50 minute A. M.

21. I hereby certify that I attended the deceased from 2:00a.m.
December 9, 1944 to 9:50a.m. Dec. 9, 1944,
that I last saw her alive on December 9, 1944,
and that death occurred on the date and hour stated above.

8. AGE:			If less than one day
Years	Months	Days	
<u>2</u>	<u>2</u>	<u>14</u>	hr. _____ min.

Immediate cause of death Cerebral Edema

Due to Congenital cyst of right frontal lobe of the brain.

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

10. Usual occupation Unemployed

11. Industry or business _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy Same as above

MOTHER FATHER { 12. Name Clarence House

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

14. Maiden name Hazel Harris

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) burial (b) Date thereof 12/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director H. E. Brown

(b) Address 1729 Lydia

19. (a) 12-14-44 (b) H. E. Brown
(Date received local registrar) (Registrar's signature)

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 H. E. Brown (M. D. or other)

Address Gen. Hosp. #2 600 E. 22nd Date signed 12-11-

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 J. J. Manlove
Licensed Embalmer No. 3994
P. O. Address 2583 Highland

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.