

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40181

FILED DEC 22 1944
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4926

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:
Osteopathic Hosp. 11th & Harrison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days 0
(Specify whether years, months or days)

In this community 32 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Norman Jack

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex 0 male

5. Color or race white

6. (a) Single, widowed, married, divorced 3 divorced divorced

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased: 5 16 1881
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>6</u>	<u>18</u>	_____ hr. _____ min.

9. Birthplace: Atherton Mo 1
(City, town, or county) (State or foreign country)

10. Usual occupation Boilermakers helper

11. Industry or business Retired

MOTHER FATHER

12. Name Robert W. Jack 9

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

14. Maiden name Nancy Brewer

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

16. (a) Informant Oscar Jack (son)

(b) Address 1122 Prospect

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12/7/44
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo.

19. (a) Dec 6, 1944 (b) J E Brown
(Date received local registrar) (Registrar's signature)

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. 421 Newton
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4
year 1944 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 3 1944 to Dec. 4 1944
that I last saw him alive on Dec. 4 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Decompensated myocarditis 6 mo.
Tuberculosis complicated with pneumonia (4 days) lobar.

Due to _____

Due to _____

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

Major findings:
Of operations 108

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. J. Joseph (M.D. or other) D.O.
Address 546 1/2 St. John Date signed 12/6/44

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 John P. Sheil
Licensed Embalmer No. 3625

P. O. Address Green City, 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.