

V. S. No. 2
FORM 5-43
Rev. 5-17-39
I X36671

40184

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 22 1944

Registrar's No. 4912

Registration District No. 179

Primary Registration District No. 1007

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:
Hyde Park Convalescent Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 wk. 4
(Specify whether _____)

In this community 35 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 42

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

(d) Street No. Crest Hotel 312 East 13th.
(If rural, give location)
No

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ 17

3. (a) PRINT FULL NAME Arthur G. Jeffries

3. (b) If veteran, name war No

3. (c) Social Security No. 495-03-2927

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 3
year 1944 hour 4 minute P. M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Grace

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

7. Birth date of deceased: December 27 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 11, 1944, to Dec. 3, 1944,
that I last saw him alive on December 2, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis of the stomach

Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>11</u>	<u>23</u>	hr. _____ min. _____

Due to Carcinoma of the stomach

Due to _____

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

10. Usual occupation Bartender

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

Major findings: 46

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name John Jeffries

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

14. Maiden name Margaret

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant Mrs Grace Gates

(b) Address 402 Winn, Ave, KC.K.

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

(c) Place: burial or cremation Highland Park, K.C.

18. (a) Signature of funeral director Quirk & Robin Co.

(b) Address 20 West Linwood, K.C. MO

19. (a) Dec 5, 1944 (b) J E Brown
(Date received by 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 Edward C. Judd (M. D. or other) _____

Address 1040 Argyle Bg Date signed Dec 5 1944

(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 Charles M. Durk

Licensed Embalmer No. 3774

P. O. Address Kansas 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.