

S. No. 2
DM-2-43
v. 5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 14 1945
149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 465

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town JACKSON CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
309 GARFIELD, NORA-REA RESTORIAN
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-MO 17 DAY
(Specify whether years, months or days)

In this community 30 YEARS 4
(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. 3534 WALNUT STREET
(If rural, give location)

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

3. (a) PRINT FULL NAME MR CHAS W CEASE

(b) If veteran, name war No

(c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced 2 WIDOWED

6. (b) Name of husband or wife MRS. DIANNA CEASE

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

7. Birth date of deceased MAY-1-1899
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 28TH
year 1945 hour 5 minute 50 A.M.

21. I hereby certify that I attended the deceased from _____, 1945 to Jan 28, 1945
that I last saw him alive on Jan 27, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 85 Months 8 Days 27
If less than one day hr. _____ min. _____

Immediate cause of death Coronary Thrombosis Duration 2 hrs.

Due to Sensitivity

Due to _____

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

10. Usual occupation RETIRED R.R. MAN

11. Industry or business A.T. & SANTA FE R.R.

MOTHER FATHER { 12. Name CEASE

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

14. Maiden name _____

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

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

Major findings: 94a

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. M. C. MORRISON

(b) Address 3534 WALNUT STREET

17. (a) BURIAL (b) Date thereof JAN 30 1945
(Burial, cremation, or removal) ASHLAND CEMETERY

(c) Place: burial or cremation ST. JOSEPH, MISSOURI

18. (a) Signature of funeral director St. Joseph

(b) Address 1401 BRUSH CREEK BLDG.

19. (a) 1-30-45 (b) W. 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) (Means of injury)

23. Signature John T. Henry (M.D. or other) _____
Address 210 1/2 Indip. Ave. Date signed 29-45

W.C. Mo

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

44004 East 24th Street

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 C. Oscar. Wotkey

Licensed Embalmer No. 1767

P. O. Address Kansas City

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.