

S. No. 2
DOM-2-43
ev. 5-17-39
X35637

1187

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 6 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 339

Registration District No. 149

Primary Registration District No. 1002

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:
2302 Charlotte
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 20 yrs / (Specify whether years, months or days)

3. (a) PRINT FULL NAME John D. Hite

3. (b) If veteran, name war no

3. (c) Social Security No. 491 20 4939

4. Sex Male 5. Color or race W

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

6. (b) Name of husband or wife Lizzie E. Hite

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

7. Birth date of deceased March 7 1895
(Month) (Day) (Year)

8. AGE: Years 49 Months 10 Days 25 hr. 13 min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name John S. Hite

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

14. Maiden name Maggie Cunningham

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

16. (a) Informant Lizzie E. Hite

(b) Address 2302 Charlotte

17. (a) Removal (b) Date thereof Jan. 22 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pittsburg Kansas

18. (a) Signature of funeral director Mrs C. L. Forster

(b) Address 918 Brooklyn

19. (a) 1-22-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 2
(If outside city or town limits, write "RURAL")

(d) Street No. 2302 Charlotte
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 20
year 1945 hour 9:45 minute P M.

21. I hereby certify that I attended the deceased from _____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cowdrius schistos

Due to ulcer - schistos

Due to _____

Other conditions g/w
(Includes pregnancy within 3 months of death)

Major findings: History & Inspection

Of operations _____

Of autopsy no

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 Jacques L. Brown (M. D. or other) _____
Address 11429 profanally Date signed 1-21-45

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..... *L. H. Nice*

Licensed Embalmer No. *2570*

P. O. Address *RC 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.