

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

1204

FILED FEB 6 1945

Registration District No. _____

Primary Registration District No. _____

1602

Registrar's No. _____

343

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:
General Hospital No. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12-26-44-1-19-45
(Specify whether years, months or days)
 In this community 3 years

3. (a) PRINT FULL NAME REBECCA HUGHES

3. (b) If veteran, name war no 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife unk.
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 7 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	56	8	12	hr. _____ min.

9. Birthplace Quincy Ill. I
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER {
 12. Name William Frye
 13. Birthplace Don't know
(City, town, or county) (State or foreign country)
 14. Maiden name Mattie
 15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
 (b) Address Gen. Hosp. #2.

17. (a) Burial (b) Date thereof 1-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Lincoln Cemetery West Abilene Mo

(b) Address 1905 Vine St.
 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
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 634 Charlotte
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19
 year 1945 hour 11:20 minute a. M.

21. I hereby certify that I attended the deceased from December 26 1944 to January 19 1945;
 that I last saw her alive on January 19 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation of heart
 Duration _____

Due to Generalized sepsis

Due to Tuberculosis of Genitalia

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

Major findings:
 Of operations 20
 Of autopsy _____
 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?
(Specify type of place)

While at work _____ (e) Means of injury _____
 23. Signature D. E. Brown (M. D. or other)
 Address Gen. Hosp #2-600 6.22 Date signed 1-20-45

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.....

C. H. West

Licensed Embalmer No. *2710*

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.