V. S. No. 2
.00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 6 1945

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1211

Primary Registration District No. 1002

Registrar's No. 216

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:
K. C. General Hospital
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 12 days; (Specify whether
In this community 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1903 Agnes
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME Clifford James

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M 0

5. Color or race W

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

6. (b) Name of husband or wife Effie

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Aug 16 1903
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
41	5	2	hr. min.

9. Birthplace Kansas 1
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanics Cants

11. Industry or business for self

MOTHER FATHER

12. Name adopted Child unknown

13. Birthplace 4
(City, town, or county) (State or foreign country)

MOTHER

14. Maiden name adopted Child unknown

15. Birthplace 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Effie James

(b) Address 1903 Agnes 1

17. (a) Burial (b) Date thereof 1-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvery Cem

18. (a) Signature of funeral director Snow Mortuary

(b) Address 2315 Linwood

19. (a) 1-15-45 (b) T. E. Brown (Ass)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan. day 12
year 1945 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec. 31, 1944, to Jan. 12, 1945
that I last saw him alive on Jan. 12, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Diagnosis deferred pending further investigation	
Due to Bronchial Pneumonia	
Due to Acute glomerular nephritis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 107
Of autopsy See above

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature A. E. Upsher (M. D. or other)

Address Med. Dir. Gen'l Hosp. Date signed 1-13-45

(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..... Roy E Snow

Licensed Embalmer No..... 2560

P. O. Address..... 2315 Kenwood

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.