No. 2
M—2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 19 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 2449

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 324

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

**1. PLACE OF DEATH:**

(a) County Jackso n

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

(c) Name of hospital or institution:
9128 Shope
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 30 Days
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Misso uri (b) County Jackson

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

(d) Street No. Rural Route O ne
(If rural, give location)

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

3. (a) PRINT FULL NAME HENRY SPENCER RECORD

3. (b) If veteran, name war None

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Nettie May Records

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased April (Month) 26 (Day) 1909 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 7 | 20 | hr. min. |

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

10. Usual occupation Labore R

11. Industry or business

FATHER
12. Name Morgan Spencer Records
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Alma E. Peters
15. Birthplace Holt Co. (City, town, or county) Misso uri (State or foreign country)

16. (a) Informant Nettie May Records
(b) Address Rur l Route One, Indep. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation Blue Springs Mo.

18. (a) Signature of funeral director George C. Carson
(b) Address Independence, Misso uri

19. (a) 12-18-44 (Date received local registrar) (b) James W Ross (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 12 day 16
year 1944 hour 3 30 minute P M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on Corona , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Skull Fracture

Due to

Due to ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations History + Inspection
Of autopsy no

Duration

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) accident
(b) Date of occurrence 12-16-1944 3 30 Pm
(c) Where did injury occur? 9128 Shope (City or town) Indep (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place)
While at work? (e) Means of injury

23. Signature James C Walker (M. D. ~~or other~~ Corona)
Address 1424 Profm Bldg Date signed 12-17-44

1163

(Licensed Embalmer's Statement on Reverse Side)

FEB 16 1945

## 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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 324

SUPPLEMENTARY

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution: Rural Blue Twp.

9128 Shape (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 30 days years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3. (a) PRINT FULL NAME** Henry S. Record

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 26 (Day) 1809 (Year)

8. AGE: Years 35 Months 7 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) James W. Ross (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month Dec day 16 year 1944 hour 3:30 minute M.

21. I hereby certify that I attended the deceased from Lorraine, 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Skull fracture

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations History & Inspection

Of autopsy No

Duration

**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) Accident

(b) Date of occurrence 12/16/44 - 3:30 PM

(c) Where did injury occur? 9128 Shape Indep. Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury

23. Signature James C. Walker (M. D. or other) Coroner

Address 1924 Prof. Bldg Date signed 12/7/44

S-2[illegible]