

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED FEB 16 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5429

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 12-15-44-12-27-44  
In this community unknown (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. 566 Troost  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME VIOLA DOZIER

3. (b) If veteran, name war unknown 3. (c) Social Security No. unknown

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced unknown  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unknown 1881  
(Month) (Day) (Year)

8. AGE: Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr \_\_\_\_\_ min \_\_\_\_\_

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

10. Usual occupation unknown

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 3-14-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buried

18. (a) Signature of Dr. J. C. Brown Director

(b) Address City, Missouri

19. (a) 12-30-44 (b) T. G. Brown (N3)  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 27  
year 1944 hour 6:00 minute P.

21. I hereby certify that I attended the deceased from December 15, 1944, to December 27, 1944  
that I last saw her alive on December 27, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Avitaminosis Duration \_\_\_\_\_

Due to Senile Psychosis with oral sepsis.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 J. C. Brown (M. D. or other) \_\_\_\_\_

Address Gen. Hospital 2-602 E. 22 Date signed 12/27/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SI-71-1-0 - 11-11

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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.....

*Not Embalmed*

Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Ann A. Schuyler*

Licensed Embalmer No. *3089*

P. O. Address *1100 Len*

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.