

S. No. 2
OM-5-43
v. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5187

State File No.

FILED MAR 3 1945

Registration District No.

Primary Registration District No. 1002

Registrar's No. 773

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: 2224 Lawn
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months
(Specify whether as above same)

In this community as above same
years, months or days

3. (a) PRINT FULL NAME Beynon Page Homan

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Cora Homan 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased March 18 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

51 10 27 28 hr. min.

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

10. Usual occupation Optometrist

11. Industry or business X

12. Name William Homan

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

14. Maiden name Maggie Beynon

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

16. (a) Informant Mrs. Cora Homan

(b) Address 2224 Lawn, Kansas City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-16-45
(Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Missouri

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 2-16-45 (Data received local registrar) (b) D. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 8

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

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

(e) Citizen of foreign country? X (Yes or No)
If yes, name country X 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16th
year 1945 hour 1:25 minute A. M.

21. I hereby certify that I attended the deceased from Jan 7th
1945 to Feb 16 1945

that I last saw h. alive on 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure
Bacteremid. (E. coli)

Due to Myocardial failure
Bacteremid. (E. coli)

Due to Myocardial failure
Bacteremid. (E. coli)

Other conditions 24a
(Include pregnancy within 3 months of death)

PHYSICIAN 24a

Underline the cause to which death should be charged statistically.

Major findings: Of operations 24a

Of autopsy 24a

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 W. H. ... (M. D. or other) 0 M D
Address 1014 ... Date signed 2/16/45

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

8
3
8

*Copy Dr. Beale
12-13-45*

Dr. Tripp

MAR 19 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

Robert H Reed

Licensed Embalmer No.

3745

P. O. Address

Kansas City 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.