

FILED MAR 3 1945  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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.T.B. Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: in hospital or institution 4 days  
In this community 18 yrs  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City U.S.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1325 Woodland 3  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country D

3. (a) PRINT FULL NAME

Meridian Pope

3. (b) If veteran, name was \_\_\_\_\_  
3. (c) Social Security No. 322-14-1479

4. Sex M 5. Color or race C 6. (a) Single, widowed, divorced, married  
separated

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

7. Birth date of deceased January 23 1905  
(Month) (Day) (Year)

8. AGE: Years 40 Months 0 Days 19  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Little Rock Ark. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

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

12. Name William Pope

13. Birthplace Little Rock Ark. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Florence Stanley

15. Birthplace Little Rock Ark. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Records K.C.T.B. Hosp  
(b) Address Leeds Mo.

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

(c) Place: burial or cremation Hopland Cemetery

18. (a) Signature of funeral director H. Brown

(b) Address 1820 E. 15th St

19. (a) 2-14-45 (b) H. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 12  
year 45 hour 11:15 minute A. M.

21. I hereby certify that I attended the deceased from 2-8-45  
to 2-12 1945  
that I last saw him alive on 2-12 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 9 mos  
Duration

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

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

Other conditions: liver 30 g  
(Include pregnancy within 3 months of death)

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

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Matthew J. Brown (M. D. or other)

Address Leeds Mo. Date signed 2/13/45

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

**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.....

*H. B. Moore*

Licensed Embalmer No. 2410

P. O. Address 1820 E 18 St

**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.**