

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6331
Registrar's No. 38

FILED MAR 15 1945
Registration District No. 176

Primary Registration District No. 5568

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Fairmount Station, K.C. (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Blue Jump
817 Huttig
(If not in hospital or institution, write street number or location)

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

In this community 35 years (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 817 Huttig
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME EMMA ALICE SLACK

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 9th
year 1945 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased November 10 1858
(Month) (Day) (Year)

Immediate cause of death: Myocardial Infarction Arteriosclerosis Coronary Arteries

Due to Arteriosclerosis Coronary Arteries

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years 86 Months 2 Days 29 If less than one day _____ hr. _____ min.

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

Major findings: _____

Of operations: _____

Of autopsy: _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business Housewife

12. Name Daniel Kisting

13. Birthplace Unknown _____ 9
(City, town, or county) (State or foreign country)

14. Maiden name Angie Weitz _____ 9

15. Birthplace Unknown _____ 9
(City, town, or county) (State or foreign country)

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 Fred W. Smith (M. D. or other) _____

Address Fairmount Mo. Date signed _____

16. (a) Informant Mrs James E. Kesting

(b) Address 817 Huttig, Kansas City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 12 45
(Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director George E. Carson

(b) Address Indipendence, Missouri

19. (a) 2-12-45 (Date received local registrar)

(b) J. Maxwell Ross (Registrar's signature)

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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Lloyd C. Brown
Licensed Embalmer No. 4199
P. O. Address Independence, 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.