

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 24 1945

Registration District No. 147

Primary Registration District No. 55694237

Registrar's No. 185

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
5804 Raytown Road 1
(If not in hospital or institution, write street number or location)

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

In this community 25 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49

(c) City or town Raytown 0
(If outside city or town limits, write "RURAL")

(d) Street No. 5804 Raytown Road 0
(If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Susie Amanda Thompson

3. (b) If veteran, name war _____

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 14
year 1945 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from
DEC 24 1944, to JAN 14 1945;
that I last saw h. ER alive on JAN 14 1945;
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 deceased years

7. Birth date of deceased: Jan 29 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>11</u>	<u>15</u>	hr. _____ min. _____

Immediate cause of death: CEREBRAL HEMORRHAGE Duration 1 DAY

Due to HIGH BLOOD PRESSURE 5 YRS

Due to _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Daniel B. Hudson

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

14. Maiden name Mary Elizabeth North

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

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

Major findings: 120
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. D. L. Brown

(b) Address 5804 Raytown Rd. Raytown Mo.

17. (a) Burial (b) Date thereof Jan 17 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hills Cem. Raytown Mo.

18. (a) Signature of funeral director C. Clark Heger

(b) Address Raytown Mo.

19. (a) 1-16-45 (b) Madred Brown
(Date received local registrar) (Registrar's signature)

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature A. L. Henson (M. D. or other) _____
Address 3400 East 31 RCHM Date signed JAN 16 45

MAR 31 1965

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 *C. Clark Hegert*
Licensed Embalmer No. 3983
P. O. Address Raytown 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.