V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 5 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8765

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1332

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Hours. (Specify whether years, months or days)
In this community 15 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 40
(c) City or town Kansas City Mo. 5
(If outside city or town limits, write "RURAL")
(d) Street No. 2803 East 31st, Street. 11
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William J. RECTOR.
3. (b) If veteran, name war None
3. (c) Social Security No. none
4. Sex Male 1
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced 3
6. (b) Name of husband or wife unk
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 30th, (Day) 1885 (Year)

8. AGE: Years 59 Months 10 Days 16 If less than one day hr. min.

9. Birthplace MonteVallo (City, town, or county) Missouri 1 (State or foreign country)
10. Usual occupation Painter
11. Industry or business St. Joseph Hospital.

MOTHER FATHER
12. Name John R. Rector
13. Birthplace Missouri 0 (City, town, or county) (State or foreign country)
14. Maiden name Mary C. Guinn
15. Birthplace Cefar County (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Mrs. J.L. Clowney
(b) Address 1412 Oakley
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Alta Vista Kansas
18. (a) Signature of funeral director Mellody-McGilley
(b) Address Kansas City Mo.
19. (a) 3-22-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16th year 1945 hour 7-55 minute P. M.
21. I hereby certify that I attended the deceased from Pathologist 19..; that I last saw h. alive on 19..; and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary sclerosis
Chronic myocarditis
~~Due to~~
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy As above

Duration

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 0
23. Signature Maline Sherwood (M. D. ~~or other~~)
Address Pathologist Date signed
St. Joseph Hospital, K.C. Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.