

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 29 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1185

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
538 1/2 main ST 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 Do not know (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

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

(d) Street No. 538 1/2 main ST
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Charles Richard

3. (b) If veteran, name war no 3. (c) Social Security No. unk.

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

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

7. Birth date of deceased 1883
(Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Do not know 9
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

MOTHER FATHER

11. Industry or business _____

12. Name Do not know

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

14. Maiden name know

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

16. (a) Informant Coroner office

(b) Address Kansas city mo

17. (a) Burial (b) Date thereof 3/19/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvary KC Mo

18. (a) Signature of funeral director Robert E. Brown

(b) Address Kansas city mo

19. (a) 3-13-45 (b) R. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
year 1945 hour 4 minute 20 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia

Due to _____

Due to _____

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy as - History & Anguelin

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 3 Crown

23. Signature Jimmie Walker (M. D. or other) _____
Address 1924 pipen rd Date signed 3-8-45

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

148
3
8

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 Francesco Walter
Licensed Embalmer No. 2744
P. O. Address K. C. 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.