U. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15781

Registration District No. 149 | Primary Registration District No. 1002 | Registrar's No. 2142

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: Wheatly Providence Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether
In this community: 42 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Kansas (b) County: Wyandotte
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 1941 North 4th St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ethel May Bledsoe
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Arthur Bledsoe
6. (c) Age of husband or wife if alive: 64 years
7. Birth date of deceased: Feb. 20, 1888 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
57	2	~~25~~ 26	hr. min.

9. Birthplace: Carrolton (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Charles May
13. Birthplace: (City, town, or county) Va. (State or foreign country)
MOTHER 14. Maiden name: Julia Sanford
15. Birthplace: (City, town, or county) Mo. (State or foreign country)
16. (a) Informant: Hospital Records
(b) Address: 19th Forest K.C. Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Carrolton Mo.
18. (a) Signature of funeral director: Alice Bailey
(b) Address: 2065 North 5th St.
19. (a) 5-18-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 16 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 5/11/45 to 5-16-45, that I last saw h alive on 5-16-45 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Failure Cessation of Heart — Duration
Due to:
Due to: Carl Hoffmann (M.D.)
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations: 92-D
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: J. P. Thompson (M. D. or other)
Address: 3112 N. 5th St. Date signed: 5/16/45

(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.