S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 28 1945

Registration District No. 1009

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 15885

Registrar's No. 2051

8358

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: General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3-9-45-4-8-45 (Specify whether years, months or days)

In this community: unknown.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

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

(d) Street No.: 582 Troost (rear)
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: AMOS HARSHAW

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Male

5. Color or race: Negro

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

6. (b) Name of husband or wife: unknown

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

7. Birth date of deceased: November (Month) 10 (Day) 1874 (Year)

8. AGE: Years 70 | Months 4½ | Days ~~28~~ 28 | If less than one day hr. min.

9. Birthplace: (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name:
15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant: Record Clerk

(b) Address: General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-9-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Leeds

18. (a) Signature of funeral director: Wm. A. Lohmeyer

(b) Address: City Mortician

19. (a) 5-10-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8 year 1945 hour 12:40 minute A M.

21. I hereby certify that I attended the deceased from March 9, 1945 to April 8, 1945 that I last saw him alive on April 8, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Foecal Fistula- Post Operative — Duration

Due to: Generalized Peritonitis

Due to: Intestinal Obstruction

Other conditions: Ruptured Appendix
(Include pregnancy within 3 months of death)

Major findings:
Of operations: 21.1

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? Means of injury:

23. Signature: (M. D. or other)

Address: Gen. Hosp. #2-600 E. 22 St. Date signed: 4-12-45

(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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Wm A. Lohmeyer

Licensed Embalmer No. 3689

P. O. Address 15 E 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.