

S. No. 2
 OM-2-43
 v. 5-17-39
 I X35697

15969

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 1 1945
 749

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2100

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 4-29-45-5-10-45
 (Specify whether years, months or days) 15 yrs.

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. 2114 Charlotte
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT WILL MASON FULL NAME _____

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced. Single

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

7. Birth date of deceased March 10 1902
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>2</u>	<u>0</u>	hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Bill Mason

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

14. Maiden name Lou Pitt Miss. /

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 5-14-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director Arthur Bros.

(b) Address 2200 E. 12th St. K.C. Mo

19. (a) 5-14-45 Steraldine Holmes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10
 year 1945 hour 9:35 minute P M.

21. I hereby certify that I attended the deceased from April 29 1945 to May 10 1945
 that I last saw him alive on May 10 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death General Paresis

Due to _____

Due to 30 to

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

Major findings:
 Of operations _____
 Of autopsy _____

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) Means of injury ?

23. Signature Dr. Hoop (M. D. or other) _____
 Address Hoop #2-6006 22 Date signed 5-11-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

18
 38
 9

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.....

A. T. Moore

Licensed Embalmer No.....

948

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.