DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 2 1945

Registration District No. 152

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17102

Primary Registration District No. 5575

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
7911 Main
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community 23 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 49

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

(d) Street No. 7911 Main
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lorelei B. Bacus

3. (b) If veteran, name war No

3. (c) Social Security No. 494-12-7336

4. Sex Female

5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joe Bacus

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased May 2 1902 (Month) (Day) (Year)

8. AGE: Years 43 Months 0 Days 11 If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Myrland (City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business

MOTHER FATHER

12. Name Wm. Trench

13. Birthplace No Record (City, town, or county) (State or foreign country) 4

14. Maiden name No Record

15. Birthplace No Record (City, town, or county) (State or foreign country) 4

16. (a) Informant Joe Bacus

(b) Address 7911 Main

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 45 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Harlan Roy

(b) Address 7406 Wornall K.C. Mo.

19. (a) 5/16/45 (Date received local registrar) Ivo Rolumbus Donnell (Registrar's signature)

Dr. Emma G. Hodges (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13th year 1945 hour ..... minute ..... M.

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

Immediate cause of death Cause determined pending further lab. investigation

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation

Of autopsy To be reported later

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) Not yet determined

(b) Date of occurrence

(c) Where did injury occur? Kans City Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)

While at work? no (e) Means of injury

23. Signature F. H. Burns (M. D. or [redacted])

Address Kans C Mo Date signed 5/15/45

AUG 9 1945

JUL 5 1945

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 Harlyn Roe

Licensed Embalmer No. 2810

P. O. Address 17 C. mi.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
45
3880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 154 Primary Registration District No. 5575 Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Lorelei B Bacus

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 2 (Day) 1902 (Year)

8. AGE: Years 43 Months 0 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
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

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May 3 year 1945 hour minute 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 Brown Tumor

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 5 Td

Of autopsy Brown Tumor
Lab findings no evidence

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 P H Owens (M. D. or other)

Address K.C. Mo Date signed 6/6/45

SUPPLEMENTARY

AUG 9 1945

20161