

S. No. 2
 DM-8-43
 v. 5-17-39
 I X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

1945
 State File No. 2454
 Registrar's No.

FILED JUN 25 1945
 Registration District No. 149

Primary Registration District No. 1002

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

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
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 21 days
(Specify whether
 In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 2008 Kensington
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Thomas Cox
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 8
 year 1945 hour 3 minute 45 A. M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife None
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 13 1945
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
May 17 1945 to June 8 1945
 that I last saw him alive on June 8 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
0 2 25 hr. _____ min.

Immediate cause of death:
Hypertrophic stenosis of pylorus
postoperative shock
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings:
 Of operations _____
 Of autopsy See above

9. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation None
 11. Industry or business _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.
15782

MOTHER FATHER
 12. Name Clarence Cox
 13. Birthplace Memphis Tenn.
(City, town, or county) (State or foreign country)
 14. Maiden name Shirley Mae Nesbitt
 15. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Shirley Mae Cox
 (b) Address 2008 Kensington K.C. Mo.
 17. (a) Burial (b) Date thereof 6/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

23. Signature Charles W. Sealy (Specify type of place) _____
(M. D. or other)
 Address Gen. Hospital Date dictated _____

18. (a) Signature of funeral director Melody-McGilley-Eylar
 (b) Address 1800 Linwood Bldg. K.C. Mo.
 19. (a) 6-9-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

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 Blair E. Beck

Licensed Embalmer No. 4063

P. O. Address Kansas City, 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.