

WED JUN 27 1945
Registration District No. 150

Primary Registration District No. 5572

State File No. _____
Registrar's No. 64

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Jackson County Home for Aged
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 years 5
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson ⁴⁸

(c) City or town Done Jack ⁰
(If outside city or town limits, write "RURAL") ⁰

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

(e) Citizen of foreign country? no (Yes or No) ⁰

If yes, name country _____

3. (a) PRINT FULL NAME Jesse Howard

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex M | 5. Color or race W

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 Oct. 10 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>7</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace Done Jack Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant Jackson County Home

(b) Address St. Independence, Mo.

17. (a) Burial (b) Date thereof 5-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leis Summit Mo

18. (a) Signature of funeral director J. B. Langford

(b) Address Leis Summit Mo

19. (a) May 19-45 (b) F. M. Schuck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1945 hour 3 minute 9 M.

21. I hereby certify that I attended the deceased from Jan 1, 1945, to May 18, 1945
that I last saw him alive on May 17, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to _____

Due to 162 hr

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)

(e) Means of injury _____

23. Signature J. R. Greene (M. D. or other) ¹
Address Independence Date signed 1/18/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

8000

JUL 27 1953

95b

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.....

H. B. Ramseyford
6833

Licensed Embalmer No.

P. O. Address: *Lees Summit, 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.