

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23006**

FILED JUL 17 1945

Registration District No. **79**

Primary Registration District No. **1002**

Registrar's No. **2822**

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: Kansas City Tuberculosis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 days
(Specify whether years, months or days)

In this community 30 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson Co

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

(d) Street No. 203 E. 11th St
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME HARRY HOWARD

3. (b) If veteran, name war no

3. (c) Social Security No. unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1 year 1945 hour 10 minute 00 P.M.

21. I hereby certify that I attended the deceased from June 1 1945 to July 1 1945 that I last saw him alive on July 1 1945 and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased Oct. 3 1881
(Month) (Day) (Year)

Immediate cause of death Pulmonary tuberculosis depressed

Due to.....

Due to.....

8. AGE: Years 63 Months 8 Days 28 If less than one day hr. min.

Other conditions Diabetes melitis
(Include pregnancy within 3 months of death)

Major findings: Of operations 13 b 1

Of autopsy.....

9. Birthplace St Joseph Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Window cleaner

22. If death was due to external cause, 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? College

11. Industry or business own employe - Building Work

12. Name Henry Howard

13. Birthplace Castport Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hadden

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

16. (a) Informant Ronald Clark

(b) Address Kansas City T.B. Hosp.

17. (a) removal (b) Date thereof 7-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K. C. Western Dental College

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

(b) Address Independence, Mo.

While at work?.....
(Specify type of place)

(c) Means of injury.....

23. Signature W. L. O'Connell (M. D. or other) MD

Address Kansas City Mo Date signed 7-7-45

19. (a) 7-5-45 (b) Gerardine Holmes
(Date received local registrar) (Registrar's signature)

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

8
3
8

MOTHER FATHER

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.....

Licensed Embalmer No.....

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.

10. Usual occupation Washer washer

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Howard

13. Birthplace Eastport Pennsylvania
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mary Madden

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

16. (a) Informant Kansas City Tuberculosis Hospital

(b) Address Leeds Missouri

17. (a) Removal (b) Date thereof 7-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Western Dental College

18. (a) Signature of funeral director Callier's

(b) Address Indep. Mo.

19. (a) 7-5-45 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

Other conditions Cholera melleus
(Include pregnancy within 3 months of death) discovered 5

Major findings:
Of operations _____

Of autopsy Hold for coroner's
report - 10-2-45

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 H. E. Kappeler, Jr. (M. D. or other) MD

Address Kansas City General Hosp. Date signed July 1, 45

5710 49
PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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.

1945

523004

Signed

Geo. M. Collier

Licensed Embalmer No.

3839

P. O. Address

Indep 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!