

S. No. 2  
M-5-43  
5-17-39  
X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23071**  
Registrar's No. **3052**

**FILED** AUG 49 1945  
Registration District No. **1002**

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:  
6510 E 10th St., /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether years, months or days)

In this community 4 mo 28 days

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. 6510 E 10th St.,

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

3. (a) PRINT FULL NAME Venita Louthan

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Fem / 5. Color or race Wh

6. (a) Single, widowed, married, divorced S B

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

7. Birth date of deceased 2/18/1945  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>4</u>	<u>28</u>	hr. _____ min.

9. Birthplace Stover Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Gilbert S. Louthan

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

14. Maiden name Annie McCollam

15. Birthplace Stover Mo 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Annie Louthan

(b) Address 6510 E 10th St.,

17. (a) Burial (b) Date thereof 7/21/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo

19. (a) 7-21-45 (b) Sheldine Holm  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 17 year 1945 hour 8:52 minute a M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Skull Fracture

Due to Trauma

Due to \_\_\_\_\_

Other conditions 1952  
(Include pregnancy within 3 months of death)

Major findings: 1952  
Of operations \_\_\_\_\_

Of autopsy yes as above

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) Don't know

(b) Date of occurrence 7-16-45 123

(c) Where did injury occur? 6510 E 10th St. Jackson Mo  
(City or town) (County) (State)

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

While at work? no (Specify type of place) (e) Means of Injury Trauma

23. Signature Jannet Walker 3 (M. D. or other) Coron  
Address 1424 1/2 N. 1st St. J. City Date signed 7-16-45

**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.....

*John P. Sheil*

Licensed Embalmer No. *3625*

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.**