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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED AUG 13 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. _____
Registrar's No. **3247**

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:
117 No. Askew
(If not in hospital or institution, write street number or location)

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

In this community 44 Yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson **48**

(c) City or town K. C. **?**
(If outside city or town limits, write "RURAL")

(d) Street No. 117 No. Askew **8**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME William Seward Rising

3. (b) If veteran, name war No

3. (c) Social Security No. 186-05-2308

4. Sex Male **0** 5. Color or race White

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

6. (b) Name of husband or wife Fern Rising

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

7. Birth date of deceased: May 26 1901
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>44</u>	<u>2</u>	<u>5</u>	hr. min.

9. Birthplace: Kansas City Mo. **1**
(City, town, or county) (State or foreign country)

10. Usual occupation Druggist

11. Industry or business _____

MOTHER, FATHER

12. Name William Seward Rising

13. Birthplace Rutland Vermont **1**
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Rising

15. Birthplace Alma Ill. **1**
(City, town, or county) (State or foreign country)

16. (a) Informant Fern Rising

(b) Address 117 No. Askew

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 3, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Mulberry, Ks.

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

(b) Address 2875 Under Blvd.

19. (a) 8-2-45 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1st -
year 1945 hour 10:30 minute 7 M.

21. I hereby certify that I attended the deceased from Dec 1944 to Aug 1945;
that I last saw h. alive on July 30, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Pneumonia of lungs **6 mos**

Due to Cerebral Ribs **12 mos**

Other conditions (include pregnancy within 3 months of death) 55 yrs

Major findings: Cerebral Ribs

Of operations _____

Of autopsy _____

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) _____

(b) Date of occurrence _____

(c) Where did injury occur? at home (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) _____

(a) Means of injury _____

23. Signature [Signature] (M. D. or D. O.)
Address 200 West 12th Date signed 8/2/45

Dr. Buckingham
Professional Body

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. D. Blackman*.....

Licensed Embalmer No. *3639*.....

P. O. Address *P. O. No.*.....

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.