

S. No. 2
M-2-43
5-17-39
P-1 X3563

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23204**

FILED AUG 4 1945

Registrar's No. **3185**

Registration District No. **149**

Primary Registration District No. **1002**

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: **Kans. City - Ib. Hosp. 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 months**
(Specify whether
In this community **42 years -**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Jackson 48**
(c) City or town **Kansas City 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **1306 E. 16TH. ST. 8**
(If rural, give location) **0**
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **David Shaw**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **m. 2** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife **Sula Shaw** 6. (c) Age of husband or wife if alive **53** years

7. Birth date of deceased **Sept. 12 1878**
(Month) (Day) (Year)

8. AGE: Years **66** Months **10** Days **109** If less than one day hr. min.

9. Birthplace **Moorehouse Parrish, La.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business

12. Name **Arson Shaw**

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

14. Maiden name **Sula Stokes**

15. Birthplace **Texas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Kans. City Ib. Hosp.**
(b) Address **Lesda, Mo.**

17. (a) **Anatomical** (b) Date thereof **7-27-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Brady Brown**
(b) Address **1708 Pryor**

19. (a) **7-28-45** (b) **Heroldine Holms**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **21**
year **1945** hour **2** minute **40 P.** M.

21. I hereby certify that I attended the deceased from **April 17 45** to **7-21 45**
that I last saw him alive on **7-21 45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Preliminary Tuberculosis** Duration **1 year**

Due to **13 1/2'**

Other conditions **Tuberculosis Laryngitis** **4 mo**
(Include pregnancy within 3 months of death)

Major findings:
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? (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) (a) Means of injury

23. Signature **H. R. Coffman** (M. D. or other) **M.D.**
Address **Kansas City, Mo.** Date signed **7-27-45**

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

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.

WRITE PLAINLY—USE CAPITAL LETTERS

10. Usual occupation laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Arvidus Sihou

13. Birthplace Dont. H new Va.
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Rula Stokes

15. Birthplace Texasbona Texas
(City, town, or county) (State or foreign country)

16. (a) Informant K.C. T. Be Hospital

(b) Address K.C. reg.

17. (a) Anatomical (b) Date thereof 7-27-1945
(Burial, cremation, or removal) (Month), (Day), (Year)

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

18. (a) Signature of funeral director Brady-Brown

(b) Address 1708 Tracy

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

Major findings:
Of operations _____

Of autopsy 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? _____
(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 C

23. Signature Daniel W. King (M. D. or other) M.D.

Address _____ Date signed 7-21-45

(Licensed Embalmer's Statement on Reverse Side)

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. 1271

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.