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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 1 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26350

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3538

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1115 Lydia
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 12 years

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. 1115 Lydia 3
(If rural, give location) 8
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Sallie Birkins
3. (b) If veteran, name war — no
3. (c) Social Security No. no
4. Sex Fe 3
5. Color or race Col
6. (a) Single, widowed, married, divorced Mar.
6. (b) Name of husband or wife Irab. Birkins
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased July (Month) 4 (Day) 1889 (Year)
8. AGE: Years 56 Months 1 Days 16 If less than one day hr. min.
9. Birthplace Natchez (City, town, or county) Miss. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Henry Mitchell
13. Birthplace Miss. (City, town, or county) (State or foreign country)
14. Maiden name Tisha
15. Birthplace Miss. (City, town, or county) (State or foreign country)
16. (a) Informant Sallie Birkins
(b) Address 1115 Lydia
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cem.
18. (a) Signature of funeral director Adkins Bros
(b) Address 2000 E. 12th K.C. Mo
19. (a) 8-24-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20 year 1945 hour 1 minute P.M.
21. I hereby certify that I attended the deceased from 9 August 1945 to 23 Aug 1945 that I last saw her alive on 23 Aug 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Congestive Heart Failure — Duration
Due to Hypertensive type of Heart Disease
Due to —
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 93.8
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? (Specify type of place)
While at work? (e) Means of injury —
23. Signature George H. Tift M.D. (M. D. or other)
Address 2123 E. 15th K.C. Mo Date signed 23 Aug 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.....A. T. Moore.....

Licensed Embalmer No.....948.....

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.