

S. No. 2  
OM-2-43  
v. 5-17-39  
P-1 X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29734

FILED OCT 8 1945

State File No. \_\_\_\_\_  
Registrar's No. 4018

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: R.C. Th. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 years  
In this community 30 years  
years, months or days (Specify whether)

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. 920 Wyandotte  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Claude Rackley  
(b) If veteran, name war no  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 24  
year 1945 hour 8 minute 30 a.m.

4. Sex M.O. 5. Color or race W.  
6. (a) Single, widowed, married, divorced 0  
(b) Name of husband or wife \_\_\_\_\_  
(c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from Aug 3 1945 to Sept 24 1945  
that I last saw him alive on Sept 24 1945  
and that death occurred on the date and hour stated above.

7. Birth date of deceased: Aug 194 1873  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
73 1 5 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Pulmonary Hemorrhage Duration 5 min.  
Due to: Pulmonary Tuberculosis 7 yrs.  
Due to: \_\_\_\_\_

9. Birthplace: Atsumwa Iowa  
(City, town, or county) (State or foreign country)  
10. Usual occupation: attorney

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: 138  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Joseph Rackley  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Pete Avilda  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant R.C. Th. Hospital  
(b) Address Leys, Mo  
17. (a) Cremation (b) Date thereof 10-1-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Elmwood Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director: Tom Anderson  
(b) Address City, Missouri  
19. (a) 9-29-45 (b) Geraldine Holma  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature D. L. Coffman (M. D. or other) M.D.  
Address Kansas City, Mo Date signed 9-28-45

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

**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.....

*Wm A. Schmeizer*

Licensed Embalmer No.....

*3089*

P. O. Address.....

*15 E. 7th*

**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.**