V. S. No. 2
00M—5-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 8 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 29843

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3983

**1. PLACE OF DEATH:**
(a) County Jackson
(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gen. Hosp. #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9/21/45 to 9/24/45 (Specify whether years, months or days)
In this community Big Jno

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 2014 E. 12th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3. (a) PRINT FULL NAME** Jessie Mae Powell

3. (b) If veteran, name war —
3. (c) Social Security No. None

4. Sex F 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lorenzo Powell
6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased 10/16/06 (Month) (Day) (Year)

8. AGE: Years 38 | Months ~~7~~ 71 | Days ~~22~~ 8 | If less than one day ___ hr. ___ min.

9. Birthplace Alabama (City, town, or county) 1 (State or foreign country)
10. Usual occupation housewife
11. Industry or business
MOTHER FATHER
12. Name Jessie Taylor
13. Birthplace Alabama (City, town, or county) 1 (State or foreign country)
MOTHER
14. Maiden name Lela Hendrix
15. Birthplace Arkansas (City, town, or county) 1 (State or foreign country)
16. (a) Informant Lorenzo Powell
(b) Address 2014 E. 12th St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery
18. (a) Signature of funeral director Fitz Appleton Jones
(b) Address City
19. (a) 9-27-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month September day 24 year 1945 hour ___ minute ___ M.
21. I hereby certify that I attended the deceased from 9/21/45, 19__, to 9/24/45, 19__, that I last saw her alive on September 24, 1945 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Tuberculous Meningitis | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) 14 | |

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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature G. O. Turner M.D. (M. D. or other)
Address Gen. Hosp#2 Date signed

(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 C. H. West

Licensed Embalmer No. 2710

P. O. Address K. C. 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.**