S. No. 2
M—2-43
. 5-17-39
I X35627

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32695

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4362

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: RCTB HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1YR - 2 MOS - 17 days (Specify whether years, months or days)

In this community 15 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: JACKSON 18

(c) City or town: KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 562 TRACY AVE 7
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: CONRAD-DELORES

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: F 3

5. Color or race: NEGRO

6. (a) Single, widowed, married, divorced: S 0

6. (b) Name of husband or wife:

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

7. Birth date of deceased: MARCH (Month) 27 (Day) 1930 (Year)

8. AGE: Years 15 Months 6 Days 25 If less than one day hr. min.

9. Birthplace: KANSAS CITY (City, town, or county) MO 0 (State or foreign country)

10. Usual occupation: SCHOOL GIRL

11. Industry or business:

MOTHER FATHER

12. Name: CONRAD-JAMES

13. Birthplace: (City, town, or county) MISSISSIPPI (State or foreign country)

14. Maiden name: STOVALL - MATTIE

15. Birthplace: (City, town, or county) ARKANSAS (State or foreign country)

16. (a) Informant: RCTB HOSPITAL

(b) Address: LEES, MISSOURI

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/24/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Lincoln Gem

18. (a) Signature of funeral director: Jackins Bros

(b) Address: 1729 Lydia

19. (a) 10-24-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 22 year 1945 hour 9 minute 50 A.M.

21. I hereby certify that I attended the deceased from 8-5, 1944, to 10-22, 1945 that I last saw h. alive on 10-22, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Hemorrhage	few minutes
Due to: Pulmonary Tuberculosis	2 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death): 13 b	

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: E

23. Signature: D. L. Coffman (M. D. or other) M.D.

Address: Kansas City Mo Date signed 10/27/45

361

(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 D. J. Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

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.