

No. 2
1-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

32820

FILED OCT 29 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

4306

Registration District No.

149

Primary Registration District No.

1002

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

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:
559 Westport Road /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community About 1 year
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 559 Westport Road 8
(If rural, give location)
(e) Citizen of foreign country? No 0
(Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alice Moorehead

3. (b) If veteran, name war no
3. (c) Social Security No. 430-40-1943

4. Sex Female 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January - 4 - 1907
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 9 12 hr. min.

9. Birthplace Muldrow Okla. /
(City, town, or county) (State or foreign country)

10. Usual occupation Maid

11. Industry or business _____

MOTHER FATHER

12. Name Pink J. Moorehead

13. Birthplace N. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Jennie Scott

15. Birthplace Okla. /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Georgia Woolfolk

(b) Address 1320 C. Bishop, Little Rock, Ark.

17. (a) Removal (b) Date thereof 10/19/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Rock, Ark.

18. (a) Signature of funeral director E. Staring, Little Rock, Ark.
(b) Address 1212 W. Pine, Little Rock, Ark.

19. (a) 10-19-45 (b) E. Staring
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct - day 16
year 1945 hour 6 minute 58 a.m.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him alive on _____ 19____, and that death occurred on the date and hour stated above.

Immediate cause of death gun shot wounds
head and neck.

Due to gun shot

Due to _____

Other conditions no
(include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy gun shot wounds
head & neck.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Homicide
(b) Date of occurrence 10/16/45
(c) Where did injury occur? W. C. Jackson Co. - Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - 559 Westport - Old
While at work? no (Specify type of place) (e) Means of injury gunshot

23. Signature A. Williams (M. D. or other) Deputy Comm.
Address 2636 - Brooklyn Date signed 10-19-45

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..... *E. Sterling Bell*

Licensed Embalmer No. *1212*

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.