

S. No. 2
M-5-43
5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36089

FILED DEC 12 1945

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4942

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:
General Hospital #2 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo. 1 day
(Specify whether
In this community no yrs.
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. 1009 Park 8
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Henry Breckenridge

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

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

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

7. Birth date of deceased February 2, 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 9 21 hr. _____ min.

9. Birthplace Texarkana Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation Common Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name J. C. Breckenridge
13. Birthplace Texas
(City, town, or county) (State or foreign country)

{ 14. Maiden name Pinkie Scottie Decab
15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Medical Records Librarian
(b) Address General Hospital #2

17. (a) removal (b) Date thereof 12/1/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Texarkana Ark.

18. (a) Signature of funeral director Watkins Bros and
(b) Address 1729 Ogden

19. (a) 12-1-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 23
year 1945 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from September
22, 19 45, to November 23, 19 45,
that I last saw him alive on November 23, 19 45,
and that death occurred on the date and hour stated above.

Immediate cause of death Asphaxia Duration _____

Due to General Paresis
Complication of epileptic seizure

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 30

Of autopsy _____

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? _____

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

23. Signature G. C. Turner (M. D. or other) _____
Address General Hospital #2 Date signed 11/23

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.....

Lawrence Alfred Jones Registered Apprentice No. *378*
working under my personal supervision.

Signed.....

J. J. Manlove
Licensed Embalmer No. *3994*

P. O. Address *250 3 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.