

FILED DEC 6 1945 STANDARD CERTIFICATE OF DEATH

State File No. 88228

Registration District No. 280

Primary Registration District No. 6-9-64

Registrar's No. 64

1. PLACE OF DEATH

(a) County Platte
(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 years years, months or days

3. (a) PRINT FULL NAME

Jennie Bishop

3. (b) If veteran

name war no

3. (c) Social Security

No. no

4. Sex Female

5. Color of White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Jabatha Bishop

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

7. Birth date of deceased Sept 3 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	4	0	hr. min.

9. Birthplace

Callatin (City, town, or county) MO (State or foreign country)

10. Usual occupation

Home

11. Industry or business

Home

12. Name

do not know

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

do not know

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

M. Dennis C Bishop

(b) Address

Parkville MO

17. (a) Burial

(Burial, cremation, or removal) (b) Date thereof Nov 6 1945
(Month) (Day) (Year)

(c) Place: burial or cremation

Mt. Moriah - KC MO

18. (a) Signature of funeral director

L. G. Francis

(b) Address

Parkville MO

19. (a) 11-6-45

(Data received local registrar) (b) Mrs. Alpha Rollins
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Platte
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 5 mi. N. East (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

Dr. Smith Nov 3 - 12:30 P.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 3
year 1945 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct. 31 1945 to Nov. 2 1945
that I last saw him alive on Nov. 2 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Respiratory Failure (Paralysis)
Progressive Anemia

Due to _____
Carcinoma of Sigmoid

Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations H/O

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? _____ (c) Means of injury _____

23. Signature L. G. Francis (M. D. or other) D.O.
Address Liberty, MO Date signed 11-6-45

FEB 3 1949

SVL 21
3-M
x 1

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 Me

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

L. Y. Francis

Licensed Embalmer No.

3451

P. O. Address

Franklin 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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 64

Registration District No. 280 Primary Registration District No. 596F

1. PLACE OF DEATH:
(a) County Platte
(b) City or town Rural, Pettis Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: North East of Parkville
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Jennie Bishop
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 76 Months 4 Days _____ (Less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) Mo.

10. Usual occupation _____

11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) Mr. R. L. Rollins (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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) _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
Duration _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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