

S. No. 2
DM-2-43
7-5-17-39
P-1 X35927

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1352

State File No.

FILED FEB 7 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 414

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: St. Mary's Hospital 5 wks. 3 days
(If not in hospital or institution, write street number or location)
unknown

(d) Length of stay: In hospital or institution 3 years (Specify whether years, months or days)

In this community 3 years

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")
Street No. 2304 East 55th Street 8
(If rural, give location) 0

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Cleo D. Fears, Jr.

3. (b) If veteran, name war no. 3. (c) Social Security No. 993-22-9067

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Mrs. Cecil Fears 6. (c) Age of husband or wife if alive. 48 years

7. Birth date of deceased April 15, 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

51 9 8 hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Charles Fears, Jr.

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

14. Maiden name Anna Ogley

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

16. (a) Informant Mrs. Cecil Fears
(b) Address 2304 East 55th St., Kansas City, Mo.

17. (a) removal (b) Date thereof 1-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bosworth, Missouri

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 1-25-46 (b) Sheraldine Boland
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23 year 1946 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 1945 to Jan. 23, 1946

that I last saw him alive on Jan. 23, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure

Due to Chronic Coronary Arteriosclerosis (Probably longer)

Due to

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations 95C3

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? (Specify type of place) (e) Means of injury

23. Signature Harold M. Roberts (M. D. or other) C. M. D.
Address 1103 Grand, K.C. Mo. Date signed 1-24-46

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

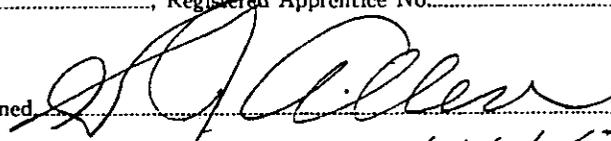
957

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



Licensed Embalmer No. 1415

P. O. Address 19 @ 150

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.