

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13333

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1746

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 No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 8 days
(Specify whether years, months or days) 10 Years

3. (a) PRINT FULL NAME Alma E. Rice

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife No Record

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

7. Birth date of deceased No Record Feb - 1 - 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>2</u>	<u>9</u>	hr. min.

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

10. Usual occupation Housework

11. Industry or business

MOTHER FATHER { 12. Name ----- Coleman

{ 13. Birthplace No record
(City, town, or county) (State or foreign country)

{ 14. Maiden name No record

{ 15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant General Hospital Record Clerk

(b) Address K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-1946
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address Kansas City, Missouri

19. (a) 4-13-46 (Date received local registrar)

(b) Geraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 414 E. 10 St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10 year 1946 hour 2 minute 55 A.M.

21. I hereby certify that I attended the deceased from March 2, 19 46 to April 10, 19 46 that I last saw her alive on April 10, 19 46 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of colon

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 462

Major findings: Of operations

Of autopsy None

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 0

23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 4-10-46

(Licensed Embalmer's Statement on Reverse Side)

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

12239

Dr. Shaw

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 *Cordell Muir*.....

Licensed Embalmer No. *3414*.....

P. O. Address *918 B. ...*.....

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.