

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40577**
Registrar's No. **5516**

FILED JAN 13 1947

Registration District No. **149**

Primary Registration District No. **1002**

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. 2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 DAYS**
(Specify whether years, months or days)

In this community **50 Years**

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. **1220 E. 12th**
(If rural, give location)

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

3. (a) PRINT FULL NAME **ARTHUR FLETCHER**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **MALE** 5. Color or race **NEGRO**

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

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

7. Birth date of deceased **May 2**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **27**, year **1946** hour **5** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **DECEMBER 17**, 19 **46** to **DECEMBER 27**, 19 **46** that I last saw him alive on **DECEMBER 27**, 19 **46** and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL VASCULAR ACCIDENT**

Due to **HYPERTENSIVE HEART DISEASE**

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

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

10. Usual occupation **Labo**

11. Industry or business _____

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Rw Ed Davis**

(b) Address **1220 E 12th**

17. (a) **Removal** (b) Date thereof **1 3 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **AC University**

18. (a) Signature of funeral director **HB moore**

(b) Address **1820 E 18th**

19. (a) **12-31-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

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)

Means of injury _____

23. Signature **[Signature]** (M. D. or other) **M.D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **12/27**

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 *AB Moore*

Licensed Embalmer No. *2410*

P. O. Address *1820 E 18th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.