

S. No. 2
M-12-45
v. 5-17-39
I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8963

FILED MAR 21 1947
199

State File No. _____

947

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH: JACKSON

(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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS (Specify whether years, months or days)
In this community 43 years

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County. JACKSON 49

(c) City or town. KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1104 TRACY 8
(If rural, give location)

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

3. (a) PRINT FULL NAME. JAMES CASON

3. (b) If veteran, name war. No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH 37 day 1, year 1947 hour 2: minute 10 A. M.

21. I hereby certify that I attended the deceased from FEBRUARY 27, 1947 to MARCH 1, 1947; that I last saw him alive on MARCH 1, 1947; and that death occurred on the date and hour stated above.

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

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

6. (b) Name of husband or wife. Mary Cason

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

7. Birth date of deceased. JANUARY 1, 1880
(Month) (Day) (Year)

Immediate cause of death. TERMINAL BRONCHO-PNEUMONIA

Duration _____

8. AGE: Years 67 Months 22 Days 20
If less than one day _____ hr. _____ min.

Due to. ARTERIOSCLEROTIC TYPE OF HEART DISEASE

Due to. GENERALIZED ARTEIROSCLEROSIS

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

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

10. Usual occupation. NONE

11. Industry or business. _____

Major findings: Of operations. _____
Of autopsy. _____

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

MOTHER FATHER { 12. Name. JIM CASON

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

14. Maiden name. MAGGIE Jones

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

16. (a) Informant. LEROY CASON (SON)

(b) Address. 1104 TRACY

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof. 3/5/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Lincoln Cemetery

18. (a) Signature of funeral director. Watkins Bros

(b) Address. 1729 Lydia Avenue

(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)

19. (a) 3-3-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature. _____ (M. D. or _____) M. D.
Address. GENERAL HOSPITAL NO. 2 Date signed 3/1/47

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

3 certified
copies

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.....

Bruce Riley

Registered Apprentice No. *1183*

working under my personal supervision.

Signed.....

J. J. Monahan

Licensed Embalmer No. *3994*

P. O. Address *2455 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.