

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

9255

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 8 1947

Registration District No. 249

Primary Registration District No. 1002

Registrar's No. 1366

1366

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 34 DAYS
(Specify whether
In this community 30 YRS.
years, months or days)

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. 1326 E. 11th
(If rural, give location)

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

3. (a) PRINT FULL NAME BERTHA ODELL MANSON

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 18,
year 1947 hour 4: minute 20 P.M.

21. I hereby certify that I attended the deceased from FEBRUARY
12, 19 47 to MARCH 18, 19 47

4. Sex FEMALE 3. Color or race NEGRO

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

6. (b) Name of husband or wife DOC MANSON

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased NOVEMBER 12 1895
(Month) (Day) (Year)

that I last saw h. ER. alive on MARCH 18, 19 47; and that death occurred on the date and hour stated above.

Immediate cause of death HYPERTENSIVE HEART DISEASE WITH DECOMPENSATION

Duration _____

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

<u>51</u>	<u>4</u>	<u>6</u>	hr. _____ min.
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Due to _____

Due to _____

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

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

10. Usual occupation HOUSEWIFE

Major findings: _____

11. Industry or business _____

Of operations _____

12. Name WILL RIGERS

Of autopsy _____

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

Underline the cause to which death should be charged statistically.

14. Maiden name ELIZA DAY

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

16. (a) Informant DOC MANSON (HUSBAND)

(b) Address 1326 E. 11TH ST.

17. (a) Removal (b) Date thereof 3-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn Cem. K.C.K.

(d) Signature of funeral director [Signature]

(e) Address 1520 N. 5th Street

19. (a) 3-24-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or ~~reg.~~ MD.)

Address GENERAL HOSPITAL NO. 2 Date signed 3/19/47

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

MOTHER FATHER

48
3
8
J

132

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

Nathan H. Hatcher

Licensed Embalmer No. *2200*

P. O. Address

1521 1/2 St.

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.