

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9325**
Registrar's No. **1022**

FILED MAR 21 1947
149

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. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 days**
(Specify whether years, months or days) **30 years**

3. (a) PRINT FULL NAME **Albert S. PLACE**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

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

6. (b) Name of husband or wife **Rosy Place** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 30, 1873**
(Month) (Day) (Year)

8. AGE: Years **73** Months **10** Days **6** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farmer (retired)**

11. Industry or business **own**

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 **Mr. Preston E. Place**

(b) Address **2629 Myrtle, K. C., Mo.**

17. (a) **Burial** (b) Date thereof **3-8-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenlawn Cemetery**

18. (a) Signature of funeral director **Melody-McGilley-Eylar**

(b) Address **Kansas City, Missouri**

19. (a) **3-6-47** (b) **Sheldine Holman**
(Date received local registrar) (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. **623 Euclid**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **6**
year **1947** hour **12** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Feb. 23, 1947** to **March 6, 1947**
that I last saw him alive on **March 6, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac decompensation
Bronchopneumonia**

Due to _____

Due to _____

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

Major findings: **950**
Of operations _____

Of autopsy **See above**

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 **W. W. Hart** (M. D. or other) **MD**
Address **Med. Dir. Gen'l Hosp** Date signed **3-6-47**

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

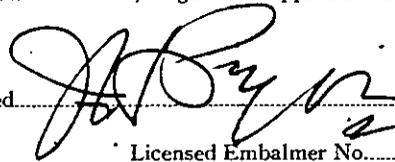
MOTHER, FATHER

Dr. J. J. J. J.
Dr. J. J. J. J.

STATEMENT BY LICENSED EMBALMER

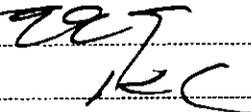
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No.....

P. O. Address.....



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.