

S. No. 2
DOM-5-43
Rev. 5-17-39
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UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH

State File No. **10968**
Registrar's No. **2578**

FILED MAR 24 1947

Registration District No. **010** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Frisco Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 3 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John Helton

3. (b) If veteran, name war no

3. (c) Social Security No. _____

4. Sex Male 5. Color or race w

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

6. (b) Name of husband or wife Rosa

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Jan. 22 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>1</u>	<u>19</u>	_____ hr. _____ min.

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

10. Usual occupation Section Foreman

11. Industry or business Frisco Lines

MOTHER FATHER

12. Name Jack Helton

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

14. Maiden name Kate MacMahon

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

16. (a) Informant Rosa Helton

(b) Address Cherokee Kan.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Mar. 11 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Cherokee, Kansas

18. (a) Signature of funeral director Jay B. Smith
7456 Manchester Ave.

(b) Address _____

19. (a) MAR 11 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kans (b) County 999

(c) City or town Cherokee
(If outside city or town limits, write "RURAL") NR 10

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
year 1947 hour 1 minute 0 P.M.

21. I hereby certify that I attended the deceased from March 7 1947 to March 11 1947
that I last saw him alive on March 10 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 2 weeks

Due to arteriosclerosis

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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)

(c) Means of injury _____

23. Signature J. C. [unclear] (M. D. or other) MD
Address 4960 Larkdale Date signed 3/10/47

MAY 28 1947

APR 3 1947

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 3454

....., Registered Apprentice No.
working under my personal supervision.

Signed David C. Gibson

• Licensed Embalmer No. 3454

P. O. Address 7456 Manchester

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.