

S. No. 2
OM-5-43
v. 5-17-39
1 X38671

13576

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 28 1947

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1716

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:
2506 E. 14th
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 27 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2506 E. 14th
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Kula Martin

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

3. (c) Social Security No. no.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 11
year 1947 hour 1 minute A M.

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife William Martin 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Aug. 1 1896
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-7 to 4-11 1947
that I last saw her alive on 4-11 1947
and that death occurred on the date and hour stated above.

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

50 8 10 hr. min.

Immediate cause of death Acute Bronchitis and pluring

Due to _____

Due to _____

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

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

10. Usual occupation Housework

11. Industry or business At Home

Major findings: Of operations 110 E

MOTHER FATHER

12. Name George Washington

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

14. Maiden name Abbie

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant William Martin, husband

(b) Address 2506 E. 14th

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

17. (a) Burial (b) Date thereof 4-17-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

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

(b) Address 2000 E. 12th K. Mo.

(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? _____

19. (a) 4-15-47 (b) Heraldine Holme
(If not received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury no

23. Signature H. G. F. Gandy (M. D. or other)

Address 207 Lincoln Bldg Date signed _____

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

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 A. T. Moore

Licensed Embalmer No. 948

P. O. Address R. C. Moore

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.