

No. 2
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5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 12 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13584

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1915

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:
On arrival to General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
in this community 7 Weeks years, months or days)

3. (a) PRINT FULL NAME Dewey Messer

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single (b) Widowed (c) Married (d) Divorced (e) Baby

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: March 10 1947
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>7 Weeks</u>				hr. min.

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

10. Usual occupation infant

11. Industry or business _____

12. Name Clarence Messer

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

14. Maiden name Hulda Bocking

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

16. (a) Informant Clarence Messer

(b) Address 706 1/2 East 12th St

17. (a) Burial (b) Date thereof 5/1/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

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

(b) Address Kansas City Mo

19. (a) 4-30-47 (b) Shardine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 706 1/2 E. 12th St
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1947 hour 10 minute 10 a M.

21. I hereby certify that I attended the deceased from _____
_____ 19____, to _____ 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to bronchial pneumonia

Due to _____

Other conditions 2
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy yes - isolate

PHYSICIAN

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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Jamell Walker (M. D. or other) _____
Address 1924 1st 1944 Date signed 4-30-47

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

MOTHER FATHER

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 J. L. Walton
Licensed Embalmer No. 2744
P. O. Address K. C. 720

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.