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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13590

State File No. \_\_\_\_\_

FILED APR 23 1947  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1629

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 1 DAY  
(Specify whether  
In this community 5 YRS.  
years, months or days)

3. (a) PRINT FULL NAME BERNICE (POWELL) MOBLEY

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex FEMALE 5. Color or race NEGRO

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased JANUARY 8, 1901  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>2</u>	<u>15</u>	hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name ALBERT E. JORDAN

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

14. Maiden name PEARLY MAE ROBINSON

15. Birthplace LITTLE ROCK ARKANSAS  
(City, town, or county) (State or foreign country)

16. (a) Informant JOSEPH POWELL (Friend)

(b) Address -406 OAK STREET

17. (a) K.C. Anatomical Soc (b) Date thereof 4-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Gen. Hosp

18. (a) Signature of funeral director Tom A. Schuyler

(b) Address City Physician

19. (a) 4-9-47 (b) M. Geraldine Holmes  
(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. 406 OAK  
(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 23,  
year 1947 hour 9: minute 35 P. M.

21. I hereby certify that I attended the deceased from MARCH 22, 1947, to MARCH 23, 1947, that I last saw her alive on MARCH 23, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Broncho-Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Edw. Frank Cook (M. D. or other) M. D.

Address GENERAL HOSPITAL NO. 2 Date signed 3/24/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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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..... *Wm. A. Schreyer* .....

Licensed Embalmer No. *3089* .....

P. O. Address *152 MD* .....

**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.**