

S. No. 2
 12-45
 5-17-39
 K47070

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED APR 23 1947
 Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13634
 State File No. _____
 Registrar's No. 1616

Primary Registration District No. 1002

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

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: 1721 E 17th St
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 45 years (Specify whether years, months or days)

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. 1721 E 17th
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Joseph M Rachelle
 3. (b) If veteran, name war no
 3. (c) Social Security No. 496-10-6487

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 1 year 1947 hour 3 a.m. M.
 I hereby certify that I attended the deceased from About 3/2/47
 _____, 19____, to _____, 19____;
 that I last saw him alive on 3/22/47
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Col
 6. (a) Single, widowed, married, divorced 2
 6. (b) Name of husband or wife unknown
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____ (Month) _____ (Day) 1887 (Year)

Immediate cause of death _____
Heart attack; sequelae of Pneumonia
2 weeks

8. AGE: Years 60 Months _____ Days _____ If less than one day hr. _____ min. _____

Duration
 Due to Pneumonia lobar 3 wks
 Due to _____

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

10. Usual occupation Painter

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Beatrice Watkins

(b) Address 2448 W. Woodland

17. (a) Burial (b) Date thereof 4-9-47 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director H. B. Moore

(b) Address 1820 E 18th

19. (a) 4-8-47 (Date received local registrar) (b) Straliding Holmes (Registrar's signature)

Other conditions _____ (Include pregnancy within 8 months of death)
 Major findings: 108
 Of operations _____
 Of autopsy _____

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? _____

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

23. Signature D. C. Walker (M. D. or other) _____
 Address 1820 E 18th St Date signed 4/2/47

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. B. Moor

Licensed Embalmer No. 2410

P. O. Address. 1820 E 18 st

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.