

S. No. 2
M-9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24072

State File No.

Registrar's No. 2872

FILED JUL 19 1947
1949

Registration District No.

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:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 DAYS
(Specify whether years, months or days)

In this community Unknown

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. 6800 ST. JOHN
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME LUCY BANKS

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 4, year 1947 hour 7: minute 50 A. M.

4. Sex FEMALE

5. Color or race NEGRO

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

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive, years 14

7. Birth date of deceased MAY 14, 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from MAY 26, 1947 to JUNE 4, 1947 that I last saw ER alive on JUNE 4, 1947 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>0</u>	<u>20</u>	hr. min.

Immediate cause of death TERMINAL BRONCHO-PNEUMONIA

Due to HYPERTENSIVE HEART DISEASE

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

Other conditions SENILITY; PEDICULI
(Include pregnancy within 3 months of death)

10. Usual occupation Unknown

Due to SENILITY; PEDICULI

11. Industry or business

Major findings: Of operations 93 d

Of autopsy

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant General Hospital No. 2

(b) Address 222 140 East St.

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

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

17. (a) University of M.C. (b) Date thereof 7-7-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation University of M.C.

(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?

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

(b) Address 1820 E. 18th St.

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

19. (a) 7-7-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature Dr. Frank E. ... (M. D. or other) M.D.

Address GENERAL HOSPITAL NO. 2 Date signed 6/5/47

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.....

HB Moore

Licensed Embalmer No. *2410*

P. O. Address *1820 E 18th*

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.