

No. 2  
1747  
5-1739

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24493

National Office of Vital Statistics

State File No. ....

FILED AUG 9, 1947  
Registration District No. ....

Primary Registration District No. 5575

Registrar's No. 27

1. PLACE OF DEATH:

(a) County. Jackson  
(b) City or town. Rural Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution.  
8826 Sleepy Hollow Road /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 49 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Jackson  
(c) City or town. Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8826 Sleepy Hollow Road  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME MRS. FLEETA M JAMESON

3. (b) If veteran, name war. No  
3. (c) Social Security No. None

4. Sex. Female / 5. Color or race. White  
6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife. Frank M Jameson  
6. (c) Age of husband or wife if alive. 51 years

7. Birth date of deceased. June 19 1898  
(Month) (Day) (Year)

8. AGE: Years 49 Months 1 Days 6  
If less than one day . hr. min.

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

10. Usual occupation. Housewife

11. Industry or business.

12. Name. Alfred F Whelan

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

14. Maiden name. Fleeta C Cox

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

16. (a) Informant. J M Jameson

(b) Address. 8826 Sleepy Hollow Road

17. (a) Burial. Burial (b) Date thereof. 7/1/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Memorial Park Cemetery

18. (a) Signature of funeral director. J. E. Whelan

(b) Address. 20 West Linwood

19. (a) 7/28/47 (b) Dr. Annie G. Hedger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 25th day July  
year 1947 about 4:00 minute. A M.

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

Immediate cause of death. Hanging

Due to.....  
Due to.....  
Other conditions (including those within months of death) Deputy Coroner

Major findings: History of Inspector  
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. D. E. Whelan M.D. 2800 - Main  
Signature..... (M. D. or other) Date signed 7/26/47

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING 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 Howard W. Farmer

Licensed Embalmer No. 4134

P. O. Address Kansas City, Mo

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.

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Registration District No. 154

Primary Registration District No. 5575-

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME Flecta M. Jameson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 49 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Due to Death due to hanging.  
Due to \_\_\_\_\_

Other conditions (Include pregnancy with results of death) \_\_\_\_\_  
Deputy Coroner

Major findings: Of operations \_\_\_\_\_  
Of autopsy History & Inspection

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Suicide  
(b) Date of occurrence 1648  
(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

**SUPPLEMENTARY**

Duration

PHYSICIAN

Underline the cause to which death could be charged statistically.

24493