

No. 2  
12-45  
17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 7 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12653**  
Registrar's No. **1878**

Registration District No. **149**

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:  
**RESEARCH HOSP.** (0)  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 DAYS** (Specify whether  
In this community **1 1/2 YRS.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **JACKSON**

(c) City or town **KANSAS CITY**  
(If outside city or town limits, write "RURAL")

(d) Street No. **317 W. 50 ST. TERRACE**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **MRS. RUTH K. JANSSEN**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NO**

4. Sex **F** / 5. Color or race **W**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **FRANS JANSSEN**

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

7. Birth date of deceased **DEC. 26 1897**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **29th**  
year **1948** hour **3:50** minute **P** M.

21. I hereby certify that I attended the deceased from **Jan. 1947**  
19 **1948** to **April 29** 19 **48**.

that I last saw h. p. r. alive on **April 29** 19 **48**.  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration

8. AGE:

Years	Months	Days	If less than one day
<b>50</b>	<b>4</b>	<b>3</b>	hr. min.

Due to **Carcinoma of pancreas**

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

Due to

10. Usual occupation **HOME**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

Major findings: **46 g**

MOTHER FATHER { 12. Name **JOHN KIRKPATRICK**

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

Of operations

Of autopsy **as above**

Underline the cause to which death should be charged statistically.

14. Maiden name **unknown**

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

16. (a) Informant **FRANS JANSSEN**

(b) Address **317 W. 51 ST. TERRACE**

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

17. (a) **BURIAL** (b) Date thereof **5-1-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FOREST HILL**

(c) 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?

18. (a) Signature of funeral director **STINE & MCCLURE**

(b) Address **KANSAS CITY, MO.**

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

23. Signature **[Signature]** (M. D. or other) **GMP**

Address **95 Prof. Bldg -** Date signed **4-29-48**

19. (a) **4-30-48** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

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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..... *Robert D Reed* .....

Licensed Embalmer No. *3745* .....

P. O. Address..... *A. C. 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.**