

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12972
1563
Registrar's No. _____

FILED APR 17 1948
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:
319 E. 9th Gladstone Hotel
(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 1 Day
years, months or days)

3. (a) PRINT FULL NAME Mrs. Mildred Christel White

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

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

6. (b) Name of husband or wife Dr. Chas. H. White 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Dec. 2 1912
(Month) (Day) (Year)

8. AGE: Years 35 Months 7 Days 5
If less than one day
hr. min.

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

10. Usual occupation Home

11. Industry or business _____

12. Name Roy Christel

13. Birthplace Ft. Scott, Ks.
(City, town, or county) (State or foreign country)

14. Maiden name Elsie McDonald

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

16. (a) Informant Dr. White CHAS. H.

(b) Address 2639 Brookridge Dr.

17. (a) Burial (b) Date thereof 4-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Stine & McClure

(b) Address Kansas City, Mo.

19. (a) 4-9-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(e) State Kansas (b) County Johnson
(c) City or town Kansas City, Ks.
(If outside city or town limits, write "RURAL")
(d) Street No. 2639 Brookridge Dr.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1948 hour 7 minute 00 P. M.

21. I hereby certify that I attended the deceased from Coroner, 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 pending Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy yes

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 _____

Signature [Signature] (M. D. or other) _____

Address 1424 N. W. Hwy Date signed 4-8-48

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 V Reed*

Licensed Embalmer No. *3745*

P. O. Address..... *K.S. 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 129712
letRegistration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Nassau city
(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 _____
years, months or days3. (a) PRINT
FULL NAME Melmed White3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced _____6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____7. Birth date of deceased see _____
(Month) (Day) (Year)8. AGE: Years Months Day (If less than one day)
35 _____9. Birthplace _____
(City, town, or county) (State or foreign country)

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. (c) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

13. (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 _____ 7
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 _____

Cerebral encephalomalacia
rightDue to acute pulmonary edema
and hemorrhage bilateral

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____Of autopsy as above

PHYSICIAN _____

Underline
the cause to
which death
should be
charged sta-
tistically.

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 [Signature] (M. D. or other) _____Address 1424 2nd St Date signed 10-5-47

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

SUPPLEMENTARY

James C Walker -
Green -
Parker

~~1424~~ Prof old
1424 10 - 10 - 10

S-12972