

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 23058  
2818  
Registrar's No.

FILED JUL 19 1948

Registration District No. 1002

Primary Registration District No. 1002

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 13 DAYS  
(Specify whether years, months or days) 5 YRS.

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. 1118 TRACY  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

RICHARD DOUGLAS

3. (b) If veteran, name war no

3. (c) Social Security No. unknown

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased: JUNE (Month) 11 (Day) 1902 (Year)

8. AGE: Years 46 Months 0 Days 17 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace: MEMPHIS (City, town, or county) TENNESSEE (State or foreign country)

10. Usual occupation LABORER

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

12. Name TCM DOUGLAS

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

14. Maiden name FRANCES JONES

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

16. (a) Informant DOC JONES (FRIEND)

(b) Address 1118 TRACY

17. (a) Removal (b) Date thereof 7/8 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. School of Osteopathy

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

(b) Address 1920 E 48 St

19. (a) 7-8-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 28 year 1948 hour 9: minute 25 P. M.

21. I hereby certify that I attended the deceased from JUNE 15, 1948 to JUNE 28, 1948 that I last saw him alive on JUNE 28, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death FAR ADVANCED BILATERAL PULMONARY TUBERCULOSIS WITH CAVITATION Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 3, 8

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 (Specify type of place) (e) Means of injury \_\_\_\_\_

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

Address GENERAL HOSPITAL NO. 2 Date signed 6/29/48

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

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47  
39  
906

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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 *AB Moss*

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.**