

S. No. 300
DM-10-47
ev. 5-17-39
I 3908

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 29 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39995
Registrar's No. 5119

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: K.C. Mun. Tbc. Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days
(Specify whether years, months or days)

In this community 18 years (?)

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. 141 E. 18th
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alexander, Felix

3. (b) If veteran, name war unknown

3. (c) Social Security No. unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14
year 1948 hour 11 minute 30 A.M.

4. Sex M 2 5. Color or race Negro

6. (a) Single, widowed, married, divorced ? 9

6. (b) Name of husband or wife _____

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

7. Birth date of deceased April 28
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 2, 1948, to Dec. 14, 1948
that I last saw him alive on Dec. 14, 1948
and that death occurred on the date and hour stated above.

8. AGE: ? Years Months Days
If less than one day hr. min.

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

Immediate cause of death Pulm. Tuberculosis

Due to _____

Due to _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name William Alexander

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

14. Maiden name Bertie Harris

15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

Major findings:
Of operations 15/4

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant K. C. Mun. Tbc. Hosp.

(b) Address K. C. Mo.

17. (a) Removal (b) Date thereof 12-17-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation School of Calapathy

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

(b) Address 1820 E. 18th

19. (a) 12-17-48 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

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 G. K. Landis G. K. Landis
(M. D. or other) (M. D. or other)

Address K.C. Tbc. Hosp. Date signed _____

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 Moon

Licensed Embalmer No. 2840

P. O. Address. 1820 E 18 st

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.