

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED DEC 29 1948

Registration District No. **149**

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 # 2 0**
(If not in hospital or institution, write street number or location) **45 min**
(d) Length of stay: In hospital or institution **22 das, 21 hrs**
(Specify whether years, months or days) **30 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON** **48**
(c) City or town **KANSAS CITY** **3**
(If outside city or town limits, write "RURAL") **8**
(d) Street No. **1743 Terrace**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Hegwood CLARK HEGWOOD**
(b) If veteran, name war **No**
(c) Social Security No. **Unk.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **DECEMBER** day **11th**
year **1948** hour **1:50** minute **P.** M.
21. I hereby certify that I attended the deceased from **NOVEMBER**
19th, 19 **48**, to **DECEMBER 11th**, 19 **48**
that I last saw him alive on **DECEMBER 11th**, 19 **48**
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **WIDOWER**
6. (b) Name of husband or wife **Minnie Hegwood**
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **APRIL 3rd 1866**
(Month) (Day) (Year)

Immediate cause of death
RESPIRATORY FAILURE
Due to **CLINICAL UREMIA**
Due to **H. H. D.**

8. AGE: Years Months Days If less than one day
82 8 8 hr. min.

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

10. Usual occupation **DAY LABORER**

11. Industry or business

12. Name **HILLIARD Hegwood**
13. Birthplace **LOUISIANA**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Cousin: Frances Washington**
(b) Address **3039 Mercier**

17. (a) **Burial** (b) Date thereof **12/18/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemete y**

18. (a) Signature of funeral director **Wathins Bras**
(b) Address **1729 Lydia Avenue**

19. (a) **12-16-48** (b) **Thereldine Holmes**
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **93 d**
Of autopsy
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?
E. Frank Ellis

(Specify type of place) While at work (e) Means of injury

23. Signature **E. Frank Ellis** (M. D. or other)
Address **600 East 22nd St.** Date signed **12/13/48**

WRITE PLAINLY—USE 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 J. J. MacLone

Licensed Embalmer No. 3994

P. O. Address 1503 Highland

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.