

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27142**  
**3635**

FILED SEP 14 1951

|                                                                                                                                                                                                                                                               |  |                                                                                                        |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                    |                                                                               |                       |                                                                          |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------|--|--|--|
| BIRTH NO. _____                                                                                                                                                                                                                                               |  | REG. DIST. NO. <u>149</u>                                                                              |                                                 | PRIMARY REG. DIST. NO. <u>1002</u>                                                                                                                                                                                                                                                                                                                                                                                    |                                                    | Registrar's No. _____                                                         |                       |                                                                          |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u> <u>O</u>                                                                                                                                                                                                        |  |                                                                                                        |                                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>                                                                                                                                                                                                                                                                            |                                                    |                                                                               |                       |                                                                          |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Kansas City</u>                                                                                                                                                                    |  | c. LENGTH OF STAY (in this place)<br><u>6mo</u>                                                        |                                                 | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>Kansas City</u>                                                                                                                                                                                                                                                                                                                            |                                                    | d. STREET ADDRESS (If rural, give location)<br><u>2803 Myrtle</u> <u>3368</u> |                       |                                                                          |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>R.C.T.B. Hospital</u>                                                                                                                                                                                           |  |                                                                                                        |                                                 | d. STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                     |                                                    |                                                                               |                       |                                                                          |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Margaree</u>                                                                                                                                                                                                        |  |                                                                                                        | a. (First)                                      |                                                                                                                                                                                                                                                                                                                                                                                                                       | b. (Middle)                                        |                                                                               | c. (Last) <u>Pope</u> |                                                                          |  |  |  |
| 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Aug. 21, 1951</u>                                                                                                                                                                                              |  | 5. SEX <u>Female</u>                                                                                   |                                                 | 6. COLOR OR RACE <u>colored</u>                                                                                                                                                                                                                                                                                                                                                                                       |                                                    | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>married</u>      |                       | 8. DATE OF BIRTH<br><u>July 17, 1924</u>                                 |  |  |  |
| 9. AGE (in years last birthday) <u>27</u>                                                                                                                                                                                                                     |  | 10a. USUAL OCCUPATION (Give kind of work during most of working life, if retired)<br><u>Soda Clerk</u> |                                                 | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                     |                                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Little Rock, Arkansas</u>     |                       | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                            |  |  |  |
| 13a. FATHER'S NAME<br><u>James Stubbs</u>                                                                                                                                                                                                                     |  |                                                                                                        | 13b. MOTHER'S MAIDEN NAME<br><u>Drene Mason</u> |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                    | 14. NAME OF HUSBAND OR WIFE<br><u>James Pope</u>                              |                       |                                                                          |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service)<br><u>no</u>                                                                                                                                           |  | 16. SOCIAL SECURITY NO.<br><u>-</u>                                                                    |                                                 | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Kansas City Tuberculosis Hosp. K.C. Mo.</u>                                                                                                                                                                                                                                                                                                                                   |                                                    |                                                                               |                       | ADDRESS                                                                  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                 |  |                                                                                                        |                                                 | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                                    |                                                                               |                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 mo.</u>                         |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                        |  | 19b. MAJOR FINDINGS OF OPERATION                                                                       |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                    |                                                                               |                       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)                                                                                                                                                                                                                      |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                 | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)                                                                                                                                                                                                                                                                                                                                                                       |                                                    |                                                                               |                       |                                                                          |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)                                                                                                                                                                                                        |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                                                 | 21f. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                            |                                                    |                                                                               |                       |                                                                          |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>Feb. 21, 1951</u> , to <u>Aug 21, 1951</u> , that I last saw the deceased alive on <u>Aug. 21, 1951</u> , and that death occurred at <u>6 P. M.</u> , from the causes and on the date stated above. |  |                                                                                                        |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                    |                                                                               |                       |                                                                          |  |  |  |
| 23a. SIGNATURE <u>Edward P. Altomare</u> (Degree or title) <u>M.D.</u>                                                                                                                                                                                        |  |                                                                                                        |                                                 | 23b. ADDRESS <u>Kansas City Tuberculosis Hosp.</u>                                                                                                                                                                                                                                                                                                                                                                    |                                                    |                                                                               |                       | 23c. DATE SIGNED <u>8-21-51</u>                                          |  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>                                                                                                                                                                                                   |  | 24b. DATE <u>Aug. 25, 51</u>                                                                           |                                                 | 24c. NAME OF CEMETERY OR CREMATORY<br><u>CONWAY</u>                                                                                                                                                                                                                                                                                                                                                                   |                                                    | 24d. LOCATION (City, town, or county) (State)<br><u>CONWAY ARK.</u>           |                       |                                                                          |  |  |  |
| DATE REC'D BY LOCAL REG.<br><u>8-25-51</u>                                                                                                                                                                                                                    |  | REGISTRAR'S SIGNATURE<br><u>Geraldine Holmes</u>                                                       |                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                       | FUNERAL DIRECTOR'S SIGNATURE<br><u>E. Stealing</u> |                                                                               |                       | ADDRESS<br><u>Biller 1212 Vine</u>                                       |  |  |  |

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

**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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed *L. L. Davis*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4447

P. O. Address N. C. No.

**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.