

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40426**
5635

FILED JAN 11 1956

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City Mo		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 30 yrs		e. STREET ADDRESS (If rural, give location) 8001 Michigan	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8001 Michigan			

3. NAME OF DECEASED (Type or Print) Mr James M Booth	a. (First) James b. (Middle) M c. (Last) Booth	4. DATE OF DEATH (Month) (Day) (Year) 12-25-1955
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5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY musician		11. BIRTHPLACE (City and State or Foreign Country) Nebraska U S A	12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME John Booth	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dona Davis 8001 Michigan

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 795
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause of death unknown		
	ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Ru Crockett Jr	(Degree or title) 3	23b. ADDRESS 6027 Park St KC Mo	23c. DATE SIGNED 12-27-55
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24. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-29-55	24c. NAME OF CEMETERY OR CREMATORY National Cemetery Ft Leavenworth Kansas	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 12-27-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS France-Worrell Funeral Home	

KC MO

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Geo. C. Keahlofer

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Russell M. Fran*.....

Licensed Embalmer No. *42*.....

P. O. Address *KO*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.