

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20539**  
Registrar's No. **2500**

FILED JUL 6 1956

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

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <b>Kansas City</b> |  | c. CITY OR TOWN <b>Kansas City</b>  | 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) <b>8 Yrs.</b>  |  | e. STREET ADDRESS (If rural, give location) <b>2100 Prospect Ave.</b>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1926 Montgall Ave.</b>                      |  |   |   |

|  |             |                        |  |
|--|-------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>James</b> | b. (Middle) | c. (Last) <b>Henry</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>6-3-56</b> |
|--|-------------|------------------------|--|

|                    |                               |   |                                       |   |                        |                        |      |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|------------------------|------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH <b>Nov. 22, 1908</b> | 9. AGE (In years last birthday) <b>47</b> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | Min. |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|------------------------|------|

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <b>Vian, Okla.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
|--|-----------------------------------|---|---|

|                                      |  |   |
|--------------------------------------|--|---|
| 13a. FATHER'S NAME <b>John Henry</b> | 13b. MOTHER'S MAIDEN NAME <b>Rachel Lawrence</b> | 14. NAME OF HUSBAND OR WIFE <b>Lizzie Henry</b> |
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|  |  |   |                              |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <b>442-18-9560</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>John Henry</b> | ADDRESS <b>1507 Harrison</b> |
|--|--|---|------------------------------|

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| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>4 1/2 H</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Pulmonary Congestion</b>  |  |  |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Cardio-Renal-Vascular Disease</b><br>DUE TO (c) <b>Arteriosclerosis</b> |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic Adhesive Pleuritis</b>   |   |  |  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" 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) | 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.

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| 23a. SIGNATURE <b>W. H. Williams</b> (Degree or title) <b>Deputy Coroner</b> | 23b. ADDRESS <b>M. D. 1618 Lydia Ave</b> | 23c. DATE SIGNED <b>6/5/56</b> |
|--|--|--------------------------------|

|  |                         |   |  |
|--|-------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE <b>6-8-56</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Vian, Okla.</b> | 24d. LOCATION (City, town, or county) (State) <b>Vian, Okla.</b> |
|--|-------------------------|---|--|

|  |   |  |                           |
|--|---|--|---------------------------|
| DATE REC'D BY LOCAL REG. <b>6-7-56</b> | REGISTRAR'S SIGNATURE <b>new Marshall</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Manlove &amp; Williams</b> | ADDRESS <b>1729 Lydia</b> |
|--|---|--|---------------------------|

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

300  
48

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

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

**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.**