

RECD MAR 9 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5441
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township Rox Primary Registration District No. 100 Registered No. 640
(c) City Kansas City (d) Street No. 1928 Olive St. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Freeman
(a) Residence, No. 1928 Olive St. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 — — — — —

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Work
9. Industry or business in which work was done, as saw mill, bank, etc. at Home
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-13 1939
22. I HEREBY CERTIFY, That I attended deceased from 2-11, 1939, to 2-13, 1939
I last saw her alive on 2-13, 1939 Death is said to have occurred on the date stated above, at 9:01 a.m.
The principal cause of death and related causes of importance were as follows:

apoplexy
stroke
Date of onset 2-11-39

Other contributory causes of importance:
Neurologia

12. BIRTHPLACE (CITY OR TOWN) Lexington (STATE OR COUNTRY) Missouri
13. NAME Henry Jackson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
15. MAIDEN NAME Elizabeth Jackson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
17. INFORMANT Halter Freeman (ADDRESS) 1928 Olive St.
18. BURIAL, CREMATION, OR REMOVAL PLACE Hoodlawn DATE 2-17 1939
19. FUNERAL DIRECTOR (NAME) R. Q. Emb. & Cash (ADDRESS) 440 State Ave.
20. FILED 2/15 1939 M. M. Crowe Local Registrar.

Name of operation — Date of —
What test confirmed diagnosis? Syncope Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury _____ 19____
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? If so, specify _____
(Signed) R. Q. Emb. & Cash M. D. (Address) 1509 E. 1st St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Radford 1509 1/2 E. 18th.

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.....

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 this body is not embalmed, above space should be left blank.