REC'D SEP 6 1939

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

28146
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City K. C. Mo.
Registration District No. 399
Primary Registration District No. 1002
Registered No. 3148
(d) Street No. General Hospital #2 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 542 Chester Samuels
(a) Residence, No. 507 North Hocker St. Indep Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-12-1882
7. AGE YEARS 56 MONTHS 9 DAYS 21 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Independence Mo.

FATHER
13. NAME Henry Samuels
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisville Kentucky

MOTHER
15. MAIDEN NAME Josephine Turner
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Record Clerk General Hospt #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Wardlawn Cem DATE 8-5-1939

19. FUNERAL DIRECTOR (ADDRESS) C. E. Davis 312 E. Lexington Indep Mo

20. FILED 8 8 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-2, 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-24, 1939, to 8-2, 1939
I last saw him alive on 8-2, 1939. Death is said to have occurred on the date stated above, at 4:30 P.m.
The principal cause of death and related causes of importance were as follows:

Cellulitis of the Right Foot and Leg. Undetermined origin

Date of onset

Other contributory causes of importance:

152 b

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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) A. C. Turner, M. D.
(Address) General Hospital #2

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X12004

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer 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.)