DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 13 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42212

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4621

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 26 + Holmes + Charlotte (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State 1 (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. 514 Main (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Henry Atwood

3. (b) If veteran, name war Unk

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Unk

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: About 70 Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country) 9

10. Usual occupation 9

11. Industry or business Unk 9

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nonn
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature None

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-39 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director C. G. Theisen

(b) Address 2512 Holmes St

19. (a) Dec. 5, 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-25-39 day year hour 3 27 P minute M.

21. I hereby certify that I attended the deceased from Deputy Coroner, 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Fracture of the Skull	
Due to: Fall down Stairs 18 00	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 11-25-39

(c) Where did injury occur? K Cm (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hm (Specify type of place)

While at work? (e) Means of injury Fall down Stairs

23. Signature Russell W. Kern (M. D. or other)

Address K Cm Date signed

(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.

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 wi the above constitutes grounds for revocation of license.)

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