

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Hazel Tate Conv. Home, 2701 Linwood
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether)

In this community 1 year
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County _____

(c) City or town Rural - Near Hoxie
(If outside city or town limits, write "RURAL")

(d) Street No. Near Hoxie, Kansas
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14th
year 1940 hour two minute forty P.M.

21. I hereby certify that I attended the deceased from March, 1939, to Jan. 14, 1940;
that I last saw her alive on Jan 14, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Decompensation 10 days
Cerebral Hemorrhage 14 days
Due to Arteriosclerotic Hypertension
Due to 15/15

Other conditions Senility
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

Major findings:
Of operations _____
Of autopsy _____

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

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

(b) Date of occurrence _____

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature P. James Laminore (M. D. or other) 00
Address 1010 Chambers Bldg Date signed 1-15-40

While at work? _____
(Specify type of place) (e) Means of injury 3

3. (a) PRINT FULL NAME Mrs. Mina Fuller

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (b) Name of husband or wife Fuller 6. (c) Age of husband or wife if alive unknown years

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

8. AGE: Years 76 Months _____ Days _____
If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name Unknown Unknown

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

14. Maiden name Unknown

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

16. (a) Informant's own signature P. James Laminore
(b) Address 7246 Grand St.

17. (a) Removal (b) Date thereof Jan. 15 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hoxie, Kansas

18. (a) Signature of funeral director W. H. Newcomer's Son
(b) Address 1401 Brush Creek Blvd.

19. (a) Jan. 15, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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.

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STATE OF MISSOURI

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address K.C., Mo.

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.