DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 4 - 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 5726

Registrar's No. 951

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: K.C.Gen.Hosp.No.1 (If not in hospital or institution, write street number or location)

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

In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 29 West 1st St. (If rural, give location)

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

3. (a) PRINT FULL NAME 5 2 L CLAUD UNDERDOWN

3. (b) If veteran, name war World War

3. (c) Social Security No. --

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife --

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

7. Birth date of deceased May (Month) 14 (Day) 1888 (Year)

8. AGE: Years 52 Months 9 Days 11 If less than one day ..... hr. ..... min.

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

10. Usual occupation Laborer

11. Industry or business

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

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

16. (a) Informant's own signature Record Clerk

(b) Address K. C. General Hosp.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 29 40 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address 2332 Monitor Place

19. (a) 2-29-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25th year 1940 hour 5:05 P.M. minute ..... M.

21. I hereby certify that I attended the deceased from 2-21-40, 19..., to 2-25-40, 19...; that I last saw im alive on 2-25-40, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bilateral fibro caseous tuberculosis with Bronchopneumonia and pulmonary congestion	
Due to	
Due to 23	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy See above	

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature P. F. De Maria M.D. (M. D. or other)

Address Supt.K.C.Gen Hospital,K.C.Mo. Date signed 2-26-40

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 5-17-39 I X19511

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 Blaine E. Weilent

Licensed Embalmer No. 4075

P. O. Address 2332 Monitor Cla

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.