

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

Rev. 5-17-39
1 x1951

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13999

State File No. _____

Registrar's No. 1711

1940 399

1002

Registration District No. _____

Primary Registration District No. _____

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4-8-40-4-11-40
(Specify whether years, months or days)

In this community 50 years

8. (a) PRINT FULL NAME Birdie Payne 5711

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 12 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>6</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name: Unknown Walker
 13. Birthplace: Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name: Dora
 15. Birthplace: Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
 (b) Address General Hospital #2

17. (a) burial (b) Date thereof 4/22/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director William Barr.
 (b) Address 1729 Lydia

19. (a) 4-22-1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 1816 Grove St. Apt. 16
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11
 year 40 hour 5 minute 10 P.M.

21. I hereby certify that I attended the deceased from 4-8-, 1940, to 4-11-, 1940;
 that I last saw her alive on 4-11-, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Type of Heart Disease

Due to _____

Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

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? _____

While at work? _____
(Specify type of place) Means of injury 1

23. Signature B. Edwards (M. D. or other) _____
 Address General Hospital #2 Date signed 4-16-

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.....

S. J. Manlove

Licensed Embalmer No.....

3994

P. O. Address.....

1120 E. 23rd St

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.