

No. 2  
-11-10-39  
-5-17-39  
I X21492

FILED MAY 17 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15103

State File No. \_\_\_\_\_

Registration District No. 400

Primary Registration District No. 555313

Registrar's No. 87

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Paris Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jackson Co Home for the Aged  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City - Dismont  
(If outside city or town limits, write "RURAL")  
(d) Street No. 10119 Lexington Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Sarah Clay Rider 36  
3. (c) Social Security No. \_\_\_\_\_  
9. (b) If veteran,  name war \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 19  
year 1940 hour 11 minute 30 a.m.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Widowed 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Dec 9 - 1857  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-15, 1940 to 4-19, 1940  
that I last saw her alive on 4-18, 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 4 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death acute gastro enteritis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace unknown Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation at home

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Jessie Moore  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

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) (e) Means of injury \_\_\_\_\_

16. (a) Informant Leroy Rider  
(b) Address 10119 Lexington Ave 4/21/40  
17. (a) Burial (b) Date thereof 4/21/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St Marys Cem. Indep. Mo.  
18. (a) Signature of funeral director George E. Collier  
(b) Address Independence Mo.  
19. (a) 4/20/40 (b) John G. Baker  
(Date received local registrar) (Registrar's signature)

23. Signature J. H. Greene (M. D. or other)  
Address Independence Mo Date signed 4/21-40

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

**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.....

working under my personal supervision.

*Clyde Carson*

Registered Apprentice No. *237*

Signed.....

*Paul C. Smith*

Licensed Embalmer No. *2467*

P. O. Address *Indep. 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.