

FILED JUN 17 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17426

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1953

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3118 Thompson 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 months  
In this community 40 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2830 E 6th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9<sup>th</sup>  
year 1940 hour 4:1 minute 5 AM.  
21. I hereby certify that I attended the deceased from Sept 10<sup>th</sup>  
1937 to May 9<sup>th</sup>, 1940  
that I last saw him alive on May 9<sup>th</sup>, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
metastasis of carcinoma  
of the liver  
Due to also of right side  
of face and neck  
Due to \_\_\_\_\_

Duration  
2 1/2

Other conditions  
(Include pregnancy within 3 months of death)  
Secondary Anemia  
Major findings: Diagnosis by  
Of operations: Clinical finding  
Of autopsy: \_\_\_\_\_

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

3. (a) PRINT FULL NAME Fannie Ethel Atchison 322

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Callio H. Atchison 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 23, 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>9</u>	<u>16</u>	hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business At Home

12. Name James Herrington 4

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

14. Maiden name Harriett

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

16. (a) Informant Callie H. Atchison

(b) Address 2830 E. 6th St. K.C. Mo.

17. (a) Burial (b) Date thereof May 10-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director C.H. Blackman & Son, Inc

(b) Address 2825 Indep. Blvd. K.C. Mo.

19. (a) May 10, 1940 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

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)  
(e) Means of injury 3

23. Signature D. S. D. Ramsey, D.O. (M. or other) \_\_\_\_\_

Address 3028 E 6th St. K.C. Mo. Date signed 5-9-40

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

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**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.....

*W.D. Blackman*

Licensed Embalmer No.....

*3639*

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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

Registered No. 1953

1. PLACE OF DEATH

- (a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City..... (d) Street No..... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jessie Ethel Atchison

- (a) Residence, No. .... St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF  
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
61

- OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 5710 19 40 M. M. Brown  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9 19 40

22. I HEREBY CERTIFY, That I attended deceased from .....

I last saw him alive on ....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify..... (Signed)....., M. D.

(Address).....

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-17426