AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24251

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2861

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 7-3--40-7-12-40 (Specify whether

In this community 16 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 1937 E. 8th St., Apt. 11 (If rural, give location)

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

3. (a) PRINT FULL NAME Georgia (B) Glasper 421

3. (b) If veteran, name war No 496-16-1056

3. (c) Social Security No. No.

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased 6- (Month) 10 (Day) 1895 (Year)

8. AGE: Years 45 Months 1 Days 2 If less than one day ..... hr. ..... min.

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

10. Usual occupation Laundress

11. Industry or business Place Laundry

FATHER
12. Name Robert Kearse
13. Birthplace Unknown (City, town, or county) (State or foreign country)

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

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

(b) Address Gen. Hosp. #2

17. (a) Blue Ridge (Burial, cremation, or removal) (b) Date thereof July 18, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director E. Stitz Bible

(b) Address 1811 E 12th St. K.C. Mo

19. (a) July 17, 1940 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 12 year 40 hour 7 minute 10 PM.

21. I hereby certify that I attended the deceased from 7-3-, 1940, to 7-12-, 1940 that I last saw her alive on 7-12-, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Fibrino Purulent Peritonitis (P.O.)	
Due to Hysterectomy July 9, 1940	
Due to Uterine fibroid, (Non Malignant) 54	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Above Mentioned.	

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 G C Sierner (M. D. or other)

Address Gen. Hosp. #2 Date signed 7-15-38

(Licensed Embalmer's Statement on Reverse Side)

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.

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 E. Sterling Bell

Licensed Embalmer No. 3178

P. O. Address 1816 12th St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.