No. 2
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FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 24379

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2989

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

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 Hosp. #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours (Specify whether years, months or days)
In this community 40 years

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.: 3410 East 18th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Edward Washington 252
3. (b) If veteran, name war: None
3. (c) Social Security No. 495-03-1796
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Ethel Washington
6. (c) Age of husband or wife if alive: 48 years
7. Birth date of deceased: December (Month) 25 (Day) 1894 (Year)

8. AGE: Years 45 Months 6 Days 29 If less than one day ____ hr. ____ min.

9. Birthplace: Higginsville (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation: Truck Driver 9
11. Industry or business:
FATHER 12. Name: George Washington
13. Birthplace: (City, town, or county) Unknown (State or foreign country) 0
MOTHER 14. Maiden name: Lucy Robinson
15. Birthplace: (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Fannie Lloyd
(b) Address: 1408 Forest
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 7/28/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Higginsville, Mo.
18. (a) Signature of funeral director: Watkins Bros.
(b) Address: 1729 Lydia
19. (a) July 27, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1940 hour 8 minute 45 A. M.
21. I hereby certify that I attended the deceased from ____ 19__ to ____ 19__; that I last saw him alive on ____ 19__; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Generalized Peritonitis
Due to: Perforation of Intestines 174
Due to: Stab wound of abd
Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:
Of autopsy: Abn

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): Homicide
(b) Date of occurrence: 7-23-40
(c) Where did injury occur: Kansas City (City or town) Jackson (County) Mo (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: 5
23. Signature: [illegible] (M. D. or other)
Address: [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

M.C

## 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.....C M West.....

Licensed Embalmer No.....2710.....

P. O. Address.....K C Mo.....

**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, fact should be so stated above.**