No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24433

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3043

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: Wheatley Provident Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community 20 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. 2549 Tracy
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Sarah Radford 216

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Fe

5. Color or race Col.

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

6. (b) Name of husband or wife Dr. A. Franklin Radford

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased November (Month) 29 (Day) 1894 (Year)

8. AGE: Years 45 Months 7 Days 28 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name William Flagg
13. Birthplace Athens (City, town, or county) Georgia (State or foreign country)
14. Maiden name Julia Bonner
15. Birthplace Washington (City, town, or county) Georgia (State or foreign country)

16. (a) Informant Julia Flagg
(b) Address 2549 Tracy

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7/30/40 (Month) (Day) (Year)
(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Watkins & Sons
(b) Address 1729 Lydia

19. (a) July 30, 1940 (Date received local registrar) (b) M. McCrave (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1940 hour 7 minute 21 P. M.

21. I hereby certify that I attended the deceased from 7/23/, 1940 to 7/27/, 1940 that I last saw her alive on 7/27/, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to ____

Due to ____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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) None
(b) Date of occurrence
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? None (Specify type of place)
While at work? (e) Means of injury

23. Signature Eugene B. Eddy (M. D. or other)
Address 1214 Union Date signed 7/29/40

(Licensed Embalmer's Statement on Reverse Side)

E. 93. Perry

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 Isaac Jerome Manlon

Licensed Embalmer No. 3994

P. O. Address 1120 E. 23rd

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

If this body is not embalmed, fact should be so stated above.