

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27499**
3102

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo.
(c) Name of hospital or institution: 1518 Troost
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 20 years (Specify whether _____)
years, months or days 11 mo

3. (a) PRINT FULL NAME Ritta Walker
3. (b) If veteran, name war _____ 3. (c) Social Security No 494-12-0189

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 29, 1894
(Month) (Day) (Year)

8. AGE: Years 46 Months 0 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Madison Parish, La.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
MOTHER FATHER { 12. Name Stephens Jackson
13. Birthplace Montgomery, Ala.
(City, town, or county) (State or foreign country)
14. Maiden name Judith Wheeler
15. Birthplace Madison Parish, La.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Alberta Harris
(b) Address 1518 Troost ave.

17. (a) Burial (b) Date thereof Aug 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Samie T. Meek
(b) Address 1707 E. 18th St.

19. (a) Aug 5, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 1518 Troost
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 1st
year 1940 hour 11:30 minute _____ P. M.
21. I hereby certify that I attended the deceased from August 1st, 1940 to Aug 20, 1940
that I last saw her alive on Aug 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: cerebral hemorrhage
Due to hypertensive
retard disease
Due to arteriosclerosis
Other conditions 95 B2
(Include pregnancy within 5 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: none
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Trifillman (M. D. or other) M.D.
Address 1618 Lydia Date signed 8/5/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.