

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31031

State File No.

3594

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
North East Hospital
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME William J Combs Jr

8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Mael 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 6 1901
(Month) (Day) (Year)

8. AGE: Years 38 Months 11 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Electrician

11. Industry or business _____

12. Name William J Combs

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

14. Maiden name Julia O'Connor

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

16. (a) Informant William J Combs

(b) Address 406 North Drury

17. (a) Burial (b) Date thereof 9/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys' Cemetery

18. (a) Signature of funeral director Frank W. Robinson

(b) Address 220 W. Pinwood

19. (a) Sept. 15, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 406 North Drury
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 13
year 1940 hour 11 minute 25 P. M.

21. I hereby certify that I attended the deceased from August 26, 1940, to Sept 13, 1940

that I last saw him alive on Sept 13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failures Duration _____

Due to Bacterial Endocarditis

Due to Tuberculosis

Other conditions (Include pregnancy within 3 months of death) 277

Major findings: Of operations _____

Of autopsy Small tubercles and vegetative growths in heart valves

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 L. P. Livingston (M. D. or other) DL

Address 5909 Brookside Blvd Date signed Sept 13

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

MOTHER FATHER

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.