

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37725**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4323**

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 **11-2-40-11-6-40**
(Specify whether
In this community **7 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
City or town **Kansas City**
(If outside city or town limit write "RURAL")
(d) Street No. **2215 1/2 E. 18th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **Lillie Martin**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Negro** 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 **9 28 1912**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	28	1	8	hr. min.

9. Birthplace **Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed 9**

MOTHER FATHER { 11. Industry or business _____

12. Name **Candy Martin**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Record Clerk**

(b) Address **Gen. Hoop. #2**

17. (a) **Burial** (b) Date thereof **12-13-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Blue Ridge Lawn**

18. (a) Signature of funeral director **James M. McCay**

(b) Address **1513 Industrial**

19. (a) **11-13-40** (b) **M. M. Groves**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **6**
year **40** hour **2** minute **10** P.M.

21. I hereby certify that I attended the deceased from **11-2-** 19**40**, to **11-6-** 19**40**, that I last saw her alive on **11-6-** 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculous Meningitis**

Due to _____

Due to _____

Other conditions **24**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **Above Mentioned**

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 **A. C. Brown** (M. D. or other)

Address **Gen. Hoop. #2** Date signed **11-12-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

FILED DEC 11 1940

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.