

No. 2  
1-10-39  
-17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37743

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4341

REC'D DEC 17 1940

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 10-13-40-11-10-40  
(Specify whether years, months or days)

In this community 5 months

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. 2321 Harrison St.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Sam Williams

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10  
year 40 hour 7 minute 55 P. M.

4. Sex Male

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 00 years

7. Birth date of deceased 2 (Month) unk (Day) 1865 (Year)

21. I hereby certify that I attended the deceased from 10-13- 19 40 to 11-10- 19 40  
that I last saw him alive on 11-10- 19 40  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>9</u>	<u>—</u>	hr. _____ min.

Immediate cause of death Hypostatic Lobular Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation Laborer

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown

13. Birthplace Unknown  
(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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 11-14-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Jayce Bros

(b) Address 1708

19. (a) 11-14-40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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 J. C. Stearns (M. D. or other)

Address Gen. Hosp. #2 Date signed 11-12-40

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

SEP 16 1958

**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

*B. L. Graham*

Licensed Embalmer No. *2544*

P. O. Address *2208 West*

**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.**