No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41563

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4956

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wheatley Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 wks 1 (Specify whether

In this community 4 wks years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

(c) City or town Kansas City (If outside city or town limits write "RURAL")

(d) Street No. 419 Quindaro Blvd. (If rural, give location)

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

3. (a) PRINT FULL NAME ALBERT POSTON

3. (b) If veteran, name war Albert Poston No

3. (c) Social Security No. 510-03-9385

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Della Poston

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased June (Month) 2 (Day) 1874 (Year)

8. AGE: Years 66 Months 6 Days 20 If less than one day ..... hr. ..... min.

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

10. Usual occupation Hod Carrier 9

11. Industry or business

FATHER
12. Name Albert Poston 1
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sophia Dunn
15. Birthplace Nashville, Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Della Poston

(b) Address 419 Quindaro Blvd

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof 12-28-40 (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn Cemetery

18. (a) Signature of funeral director Alice Bailey Funeral Home

(b) Address 2065 N. 5th KCK

19. (a) 12-28-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21 year 1940 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from 11/1, 1940, to 12/21, 1940 that I last saw him alive on 12/21, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinosis of Stomach

Due to .....

Due to Carcinoma

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations As above

Of autopsy —

Duration

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) No

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Eugene B. Ewe (M. D. or other)

Address 1214 Vine, K.C. Mo Date signed 12/28/40

MC

(Licensed Embalmer's Statement on Reverse Side)

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 Edw Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 15th St KC Mo

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, above space should be left blank.