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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2901 +

Registration District No. 400 Primary Registration District No. 5553B Registrar's No. 12

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

1. PLACE OF DEATH:

(a) County Jackson Mo.

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

(c) Name of hospital or institution: 1 Block So. of Lees Summit Cemetary (If not in hospital or institution, write street number or location)

(d) Length of stay in hospital or institution at Bridge County Road (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

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

(d) Street No. in town (If rural, give location)

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

3. (a) PRINT FULL NAME Floyd Kenneth Ethridge

3. (b) If veteran, name war no

3. (c) Social Security No. 492-18-2542

4. Sex M

5. Color or race W

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 Jan (Month) 11 (Day) 1917 (Year)

8. AGE: Years 24 Months 0 Days 3 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business Farm or General.

FATHER
12. Name Wesley Ethridge
13. Birthplace Buffalo (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Anna Tucker
15. Birthplace Buffalo (City, town, or county) Mo (State or foreign country)

16. (a) Informant Wesley Ethridge

(b) Address Greenwood Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-41 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Mo

18. (a) Signature of funeral director N. B. Langsford

(b) Address Lees Summit Mo

19. (a) 1-15-41 (Date received local registrar) (b) Sara G. Gaines (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-14-41 year hour minute 9 A M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Dislocating Neck

Due to Truck Turned Over

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
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) Accident 48

(b) Date of occurrence 1-14-41

(c) Where did injury occur? Jackson Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 9 Hi Wu (Specify type of place)

While at work? (e) Means of injury Car Turned over [illegible]

23. Signature [illegible] (M. D. or other)

Address [illegible] Date signed

(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.....

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.