

S. No. 2
M-1-4-41
v. 5-17-39
I X26290

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

APR 15 1949

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9510

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 919

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 2-20-41-2-28-41
(Specify whether years, months or days)

In this community 35 years
(Specify whether years, months or days)

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. 1802 1/2 E. 18th St., 1st fl.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Baxter Givens

(b) If veteran, name war 495-09-9288 (c) Social Security No. Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 28
year 41 hour 8 minute 05 P.M.

21. I hereby certify that I attended the deceased from 2-20- to 41 to 2-28- 41
that I last saw him alive on 2-28- 41
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

7. Birth date of deceased 3 16 1890
(Month) (Day) (Year)

8. (b) Name of husband or wife Lillian Givens 6. (c) Age of husband or wife if alive Unknown

Immediate cause of death Probable Embolism

Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>11</u>	<u>12</u>	hr. _____ min. _____

Due to _____

Due to _____

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

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

10. Usual occupation Laborer

Major findings of operations Ph. Hoff, Incurial, Hernia, Seraloma of Vestibls 7/24/41

Of autopsy _____

PHYSICIAN: _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name Roland Givens

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

14. Maiden name Mattie Woods

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

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? _____

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 3 5 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. P. ... (M. D. or other) _____
Address Gen. Hosp. #2 Date signed 2-2-41

18. (a) Signature of funeral director H. B. ...

(b) Address 1820 E. 11th St.

19. (a) MAUS-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

18
3
8

18
4
5

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

41

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 me
H.B. Moore, Registered Apprentice No. _____
working under my personal supervision.

Signed H.B. Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E 18th

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, fact should be so stated above.