

FILED MAY 16 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13510
1491
Registrar's No.

Registration District No. 399

Primary Registration District No. 1007

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: K.C. General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution about 1 hr.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 2329 Holly (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Peter Aquirre
(b) If veteran, _____ name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 12th
year 1941 hour 2:00 A.M. minute _____ M. _____

4. Sex Male 0 5. Color or race wh
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 28 1941
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-12-41 19____ to 4-12-41 19____
that I last saw him alive on 4-12-41 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
2 14 _____ hr. _____ min.

Immediate cause of death Malnutrition ✓ Duration _____
Due to FA
Due to _____

9. Birthplace K.C. Mo. (City, town, or county) (State or foreign country) 0
10. Usual occupation none

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy None

11. Industry or business _____
12. Name Rupert Aquirre
13. Birthplace Mex (City, town, or county) (State or foreign country) 3
14. Maiden name Isabella Lopez
15. Birthplace Mex (City, town, or county) (State or foreign country) 3

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 Rupert Aquirre
(b) Address 2329 Hallway
17. (a) Burial (b) Date thereof 4/15/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's
18. (a) Signature of funeral director Ketterling
(b) Address 2657 Indep. Ave
19. (a) Apr 15 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature Rupert Aquirre (M. D. or other) 0
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

158

RE-0800

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

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..... *W. J. Ward*

Licensed Embalmer No..... *3991*

P. O. Address..... *5725 21/2 St*

H. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. N. 28
2-21-40
I 22625

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13510

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 1491

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town R.C.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Peter Aguirre
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Apr. day 17 - 41
year _____ hour _____ minute _____ M.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased (Month) (Day) (Year)

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

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

Immediate cause of death Malnutrition
cause not determined-no autopsy

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

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

10. Usual occupation _____

158

11. Industry or business _____

Major findings:
Of operations _____

12. Name _____

Of autopsy _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

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

MOTHER FATHER

dlw

