

No. 2
-4-41
17-39

X26390

FILED MAY 16 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13597
1578

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

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 No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

In this community 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1310 Admiral Apt. 212
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Don Perez

3. (b) If veteran, name war No

3. (c) Social Security No. NO

4. Sex Male 5. Color or race White

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: October 28, 1939
(Month) (Day) (Year)

8. AGE: Years 1 Months 5 Days 23
If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Manuel Perez

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

14. Maiden name Margorie Boyer

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

16. (a) Informant Manuel Perez

(b) Address 1310 Admiral

17. (a) Burial (b) Date thereof April 22, 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem. K. C. K.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn, K. C. Mo.

19. (a) Apr 21, 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20th
year 1941 hour 3:-- P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 4-10-41 19 to 4-20-41 19;
that I last saw him alive on 4-20-41 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobular Bronchopneumonia

Due to 12.500

Due to 175

Other conditions Central hepatic lesions; subacute yellow atrophy of liver
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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? _____

23. Signature Dr. R. R. Shaw (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____
(Specify type of place) (Means of injury)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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

.....
working under my personal supervision.

Registered Apprentice No.

Signed

J. Lewis Shuppert

Licensed Embalmer No.

P. O. Address.....

*4179
K.C. Mo*

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.