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FILED MAY 16 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13707

Registration District No. 391

Primary Registration District No. 1002

Registrar's No. 1688

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 2 days (Specify whether
In this community 40 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri (a) State (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4838 Charlotte Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country --

3. (a) PRINT FULL NAME Bess Billings

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 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 January 2 1882
(Month) (Day) (Year)

8. AGE: Years 59 Months 3 Days 26 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business --

12. Name Lewis Billings

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

14. Maiden name Maria Lanning

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

16. (a) Informant Mrs Belle Copel

(b) Address 4900 Oak KC Mo

17. (a) Burial (b) Date thereof Apr. 29, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director M. M. Crow

(b) Address 1401 Brush Creek Blvd

19. (a) Apr 29 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th
year 1941 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from 4-25-41 19 to 4-27-41 19;
that I last saw h. er alive on 4-27-41 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to Intestinal obstruction

Due to Intestinal obstruction

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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?

While at work (Specify type of place) (a) Means of injury

23. Signature Dr. Roy R. Stone (M. D. or other)
Address Med. Dir. K.C. Gen/Hospital Date signed

Duration

PHYSICIAN

Underline (the cause to which death should be charged statistically).

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

122R

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address. 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13707
Registrar's No. 1688

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
R. C. Gen. Hosp.
(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)

3. (a) PRINT FULL NAME Bessie Billings

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced A-

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH: Month Apr. day 27-41
year _____ hour _____ minute _____ 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: Peritonitis
Paralytic ileus
Intestinal obstruction
cause not determined, no autopsy

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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?

While at work? _____
(Specify type of place) (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

