

No. 2
-1-4-41
5-17-39
I X28390

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

DEPARTMENT OF COMMERCE **FILED** JUN 10 1941 MISSOURI STATE BOARD OF HEALTH
BUREAU OF THE CENSUS **STANDARD CERTIFICATE OF DEATH**

State File No. **17386**
Registrar's No. **2048**

Registration District No. 399 Primary Registration District No. 1002

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 (1)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-19-41-5-14-41
In this community 22 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. 1411 Lydia Ave. (rear)
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Fred Austin
(b) If veteran, name war —
(c) Social Security No. Unk.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 14
year 41 hour 12 minute 50 P.M.
21. I hereby certify that I attended the deceased from 4-19- 1941 to 5-14- 1941
that I last saw him alive on 5-14- 1941
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
6. (b) Name of husband or wife U. Gladys Austin
6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased 12 2 1894
(Month) (Day) (Year)

Immediate cause of death
Syphilitic Aortitis with Marked Decompensation.

8. AGE: Years 46 Months 5 Days 12
If less than one day _____ hr. _____ min.

Due to Chronic Passive Congestion
Due to _____

9. Birthplace Miss.
(City, town, or county) (State or foreign country)
10. Usual occupation Laborer

Other conditions (Include pregnancy within 3 months of death) 20 W
Major findings: Of operations 20 W
Of autopsy _____

MOTHER FATHER
11. Industry or business _____
12. Name Unknown
13. Birthplace Unk.
(City, town, or county) (State or foreign country)
14. Maiden name Unk.
15. Birthplace Unk.
(City, town, or county) (State or foreign country)

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) _____
(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 May 26-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Seeds - 4110
18. (a) Signature of funeral director W. J. Brown
(b) Address 1729 Seals
19. (a) May 26 (1941) (b) W. J. Brown
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature W. J. Brown (M. D. or other)
Address Gen. Hosp. #2 Date signed 5-25-41

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.....
.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

J. Manlove

Licensed Embalmer No. *3994*

P. O. Address *1120 E. 23rd St*

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.