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

No. 2
4-41
7-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 21418

Registration District No. 198 Primary Registration District No. 3011 Registrar's No. 76

**1. PLACE OF DEATH:**

(a) County: CLAY

(b) City or town: Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5-29-41 to 6-1-41 (Specify whether years, months or days)
In this community 4 days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Jackson 45

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: Montgall Hotel 8
(If rural, give location)

(e) Citizen of foreign country? -- (Yes or No)
If yes, name country -- 1

3. (a) PRINT FULL NAME: CAMERON, Wallace

3. (b) If veteran, name war: World War

3. (c) Social Security No.: ?

4. Sex: M 0

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married 1

6. (b) Name of husband or wife: Goldie Cameron

6. (c) Age of husband or wife if alive: yes years

7. Birth date of deceased: June (Month) 22nd (Day) 1889 (Year)

8. AGE: Years 51 Months 11 Days 10 If less than one day hr. min.

9. Birthplace: Sedalia, Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Cook

11. Industry or business:

MOTHER FATHER

12. Name: Not available

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

14. Maiden name: Not available

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

16. (a) Informant: ~~[illegible]~~ Hospital Records

(b) Address:

17. (a) Removal (Place of removal) (b) Date thereof: 6-4-41 (Month) (Day) (Year)

(c) Place: burial ~~or removal~~ Leavenworth Nat'l Cemetery Leavenworth, Kansas

18. (a) Signature of funeral director: Claude Prichard

(b) Address: Excelsior Springs, Mo.

19. (a) June 4 1941 (Date received by registrar) (b) Mrs Ria McCracken (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 1 year 1941 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 29, 1941 to June 1, 1941; that I last saw him alive on June 1, 1941; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Hemorrhage, cerebral with hemiplegia, left, severe. | |
| Due to: Hypertension, arterial. | |
| Due to: | |
| Other conditions: -- (Include pregnancy within 3 months of death) | |
| Major findings: -- Of operations: | |
| Of autopsy: No autopsy | |

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? (Specify type of place) --

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

23. Signature: S. B. Kleinman (M.D. or other) D

Address: Veterans Admin. Facility, Excelsior Springs, Mo. Date signed: 6-1-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 79-41
Date Filed

## 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: Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Spgs, 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.**