

Co. 2
4-41
17-39
X26390

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30817

State File No.

3574

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: General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8-26-41-9-10-41
(Specify whether years, months or days) 35 years

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. 4350 E. 14th - 2 W.O
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10
year 1941 hour 10: minute 08 p.m.

21. I hereby certify that I attended the deceased from August 26, 1941 to September 10, 1941.
that I last saw her alive on September 10, 1941.
and that death occurred on the date and hour stated above.

Immediate cause of death
Aortic Regurgitation
Syphilitic (?) with decompensation

Due to Manic Depressive Psychosis

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

Major findings:
Of operations _____
Of 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? _____

While at work? _____ (Specify type of place) _____ (b) Means of injury _____
23. Signature J. A. Moore (M.D. or other) _____
Address Gen. Hosp. #2 Date signed 9-11-41

3. (a) PRINT FULL NAME LUVENIA GIVENS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Son, George Jordan 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) 1873 (Year)

8. AGE: Years 68 Months 8 Days 9 If less than one day hr. _____ min. _____

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name Deceased
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Deceased
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 9-24-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Ave

18. (a) Signature of funeral director J. A. Moore
(b) Address 1820 E. 18th St

19. (a) 9/25/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

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 MC
AB Mason, Registered Apprentice No. _____
working under my personal supervision.

Signed

AB Mason

Licensed Embalmer No. 2410

P. O. Address 1820 E 18th 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.