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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33817 3749

Registration District No. 299 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. T. B. Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 mos. 10 dys. (Specify whether

In this community 21 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 047

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3 8

(d) Street No. 620 Troost (Prisoner Lead Farm) (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Bill Rone

3. (b) If veteran, name war No

3. (c) Social Security No. Unk

4. Sex Male

5. Color or race Neg.

6. (a) Single, widowed, married, divorced Sing.

6. (b) Name of husband or wife —

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

7. Birth date of deceased 4 (Month) 3 (Day) 1898 (Year)

8. AGE: Years 43 Months 6 Days 2 If less than one day hr. min.

9. Birthplace Little River Co. (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Trackman (R. R.)

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant K. C. T. B. Hosp.

(b) Address Leed, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-7-41 (Month) (Day) (Year)

(c) Place: burial or cremation Wester Dental College

18. (a) Signature of funeral director Flynn + Green Street

(b) Address 1819 E. 15th K C Mo

19. (a) 10/7/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 5 year 1941 hour 10 minute 40 A.M.

21. I hereby certify that I attended the deceased from 9-22 1941 to 10-5 1941; that I last saw him alive on 10-4 1941; and that death occurred on the date and hour stated above.

Immediate cause of death ~~Asthenia~~ Pulmonary tuberculosis

Due to Tuberculous condition

Due to 13 B

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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)

While at work? (e) Means of injury

23. Signature O. C. Heyer (M. D. or other) 0

Address K. C. T. B. Hospital, K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Edw G Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 5th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.