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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34048

Registration District No. 279

Primary Registration District No. 1002

Registrar's No. 3988

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

1. PLACE OF DEATH: Jackson
(a) County: Kansas City
(b) City or town: Kansas City
(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: 10 days
In this community: 18 Yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Emma Pettingill
3. (b) If veteran, name war: No
3. (c) Social Security No.: No

4. Sex: F. | 5. Color or race: W.
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Unknown
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: February 2nd, 1886 (Month) (Day) (Year)

8. AGE: Years 55 | Months 8 | Days 19 | If less than one day hr. min.

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

10. Usual occupation: Charles Yates None
11. Industry or business: KEX

MOTHER FATHER { 12. Name: Charles Yates
13. Birthplace: Kentucky (City, town, or county) (State or foreign country)
14. Maiden name: Susan Roberts
15. Birthplace: Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant: Record Clerk 25
(b) Address: K.C. Gen. Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 25, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Floral Hills Cem.

18. (a) Signature of funeral director: Steinhilber
(b) Address: 10/25/41
19. (a) (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 048
(a) State: Missouri (b) County: Jackson 3
(c) City or town: Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No.: 4321 Mersington (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: October day: 21st
year: 1941 hour: 2 minute: 20 P. M.
21. I hereby certify that I attended the deceased from: 10-11-41, 19, to: 10-21-41, 19;
that I last saw her alive on: 10-21-41, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death: Tbao-paresis
Due to: 30 B
Due to:
Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations:
Of autopsy: None

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?
While at work? (Specify type of place) (e) Means of injury:
23. Signature: M. M. Crowe (M. D. or other):
Address: Med. Dir. K.C. Gen. Hospital Date signed: 10-25-41

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.