No. 2
-1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 37450

DEC 22 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4245

**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 No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-28-41-11-3-41 (Specify whether
In this community 3 years
years, months or days)

**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. 1109 Campbell
(If rural, give location)

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

If yes name country

3. (a) PRINT FULL NAME ESTELLA CARTER

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife George Carter

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

7. Birth date of deceased September (Month) 16 (Day) 1905 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 1 | 18 | hr. min. |

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

10. Usual occupation Housewife

11. Industry or business

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

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

16. (a) Informant Record Clerk
(b) Address General Hospital No. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-41 (Month) (Day) (Year)
(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director Wm A Lohmeyer
(b) Address City Mortician

19. (a) 11-15-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 3
year 1941 hour 4 minute 30 p.m.

21. I hereby certify that I attended the deceased from October 28, 1941 to November 3, 1941
that I last saw her alive on November 3, 1941
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Tuberculous Peritonitis | |
| Due to 15 | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy Same as above | |

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? Means of injury

23. Signature [signature] (M. D. or other)
Address Gen Hosp #2-600 E. 22nd Date signed 11-5-41

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

. S. No. 2B
M—2-21-40
1 X22659

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# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4245

SUPPLEMENTARY

**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 (Specify whether
In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No. 1109 Campbell
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Estella Carter

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Fe

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 36 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 11-15-41 (Date received local registrar) (b) M M Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 3rd
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute generalized Peritonitis

Due to Rupture of tubo ovarian abscess

Due to and Bilateral hydrothorax

Other conditions
(Include pregnancy within 3 months of death) 139a²

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 [signature] (M. D. or other)
Address Gen. Hosp #2 Cook 22 Date signed 3-16-42

1941
S-37450