No. 2
9-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41223

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4904

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: 3307 Michigan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: (Specify whether years, months or days)
In this community: 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 049
(c) City or town: Kansas City 39
(If outside city or town limits, write "RURAL")
(d) Street No.: 6005 Locust
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Betty J. Rickes
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: Married
6. (b) Name of husband or wife: Beirt
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Feb. (Month) 15 (Day) 1861 (Year)
8. AGE: Years 80 Months 10 Days 11 If less than one day hr. min.
9. Birthplace: Kentucky (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: James J. Suddarth
13. Birthplace: Kentucky (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: No Record
15. Birthplace: Kentucky (City, town, or county) (State or foreign country)
16. (a) Informant: Beirt R. Rickes
(b) Address: 6005 Locust
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-29-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenlawn Cemetery
18. (a) Signature of funeral director: Harlyn Roe
(b) Address: 7406 Wornall Rd.
19. (a) 12-31-41 (Date received local registrar) (b) M M Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 26-41 year hour minute 4:25 A.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: Cerebral Hemorrhage
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations: 107
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: 3
23. Signature: (M. D. or other)
Address: Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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.....

Harlyn Fox, Registered Apprentice No.....

working under my personal supervision.

Signed Harlyn Fox

Licensed Embalmer No. 2810

P. O. Address K. C. 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.