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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

16927

State File No.

FILED JUN 18 1942

Registration District No. 3299 Primary Registration District No. 1002 Registrar's No. 2246

48 3 8

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)
In this community 1 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 2435½ Indiana Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

48 3 0 0

3. (a) PRINT FULL NAME Paul F. DREW.
3. (b) If veteran, name war No
3. (c) Social Security No. 486-26-3123
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 1st, (Day) 1917 (Year)
8. AGE: Years 25 Months 1 Days 4 If less than one day hr. min.
9. Birthplace Plattensburg (City, town, or county) Missouri. 0 (State or foreign country)
10. Usual occupation Laborer
11. Industry or business Viking Mgf. Co.
FATHER
12. Name Fred O. Drew
13. Birthplace Green Castle (City, town, or county) Missouri. 0 (State or foreign country)
MOTHER
14. Maiden name Lebna Harris
15. Birthplace Plattensburg (City, town, or county) Missouri 0 (State or foreign country)
16. (a) Informant Fred O. Drew.
(b) Address 2435½ Indiana Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/42 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cemetery
18. (a) Signature of funeral director Mellody-McGilley
(b) Address K. C. Mo.
19. (a) 6-9-42 (Date received local registrar) (b) M. M. Larson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 5 year 42 hour 3:00 P 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.

Duration

Immediate cause of death Gunshot wound of the head.

Due to

Due to 166

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy See 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) Homicide
(b) Date of occurrence 6/5/42
(c) Where did injury occur? Kansas City Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Street (Specify type of place)
While at work? no (e) Means of injury Shot by Police
23. Signature (M. D. or other)
Address Date signed 6/9/42

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(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. 2999

P. O. Address..... /CC

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.