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M—9-4-41
ev. 5-17-39
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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. 26475

FILED SEP 11 1942

Registration District No. 49 — Primary Registration District No. 1002 — Registrar's No. 3291

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 HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 days (Specify whether years, months or days)

In this community 6 years

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.: 1816 GROVE
(If rural, give location)

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

If yes, name country

48 3 8

3. (a) PRINT FULL NAME: LELA BENTIE

3. (b) If veteran, name war: NO

3. (c) Social Security No. 493-12-6800

4. Sex: F 3

5. Color or race: NEGRO

6. (a) Single, widowed, married, divorced: 2 widowed

6. (b) Name of husband or wife: unknown

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

7. Birth date of deceased: MAY (Month) 23 (Day) 1902 (Year)

8. AGE: Years 40 | Months 3 | Days 9 | If less than one day: hr. min.

9. Birthplace: MUSKOGEE (City, town, or county) OKLA (State or foreign country) 1

10. Usual occupation: HOUSE WORK

11. Industry or business:

FATHER
12. Name: TOM CARSON
13. Birthplace: (City, town, or county) ARKANSAS (State or foreign country) 1

MOTHER
14. Maiden name: LILLIAN BRYANT
15. Birthplace: FORT SMITH (City, town, or county) ARKANSAS (State or foreign country) 1

16. (a) Informant: K C T B HOSPITAL

(b) Address: LEES MISSOURI

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 9-3-42 (Month) (Day) (Year)

(c) Place: burial or cremation: Blue Ridge Lawn K C Mo

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

(b) Address: 1819 E 15th

19. (a) 9-3-42 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER Day 2 year 1942 hour 3 minute 55 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: Pulmonary Tuberculosis — Duration

Due to: 13 B 1

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:

Of autopsy:

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: 0

23. Signature: [illegible] (M. D. or other)

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

(Licensed Embalmer's Statement on Reverse Side)

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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 Wm. G. Flynn

Licensed Embalmer No. 2211

P. O. Address 1819 E. 15th KC 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.