

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3650

48
30
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:
St. Joseph Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days
(Specify whether years, months or days)

In this community 3 Days

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. 3531 Wyandotte Ave.
(If rural, give location)

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

If yes, name country. 0

3. (a) PRINT FULL NAME James D. GRATER.

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 30th, 1942
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>00</u>	<u>00</u>	<u>3</u>hr.min.

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

10. Usual occupation Infant

11. Industry or business.....

12. Name Leut. James D. Grater

13. Birthplace South Dakota
(City, town, or county) (State or foreign country)

14. Maiden name Irene V. Clarie. (State or foreign country)

15. Birthplace South Dakota
(City, town, or county) (State or foreign country)

16. (a) Informant Leut. James D. Grater.

(b) Address 3531 Wyandotte Ave.,

17. (a) Burial (b) Date thereof 10/3/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill.

18. (a) Signature of funeral director Melody-McGilley.

(b) Address K. C. Mo.

19. (a) 10/7/42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Oct day 30th
year 1942 hour 12:08 minute P. M.

21. I hereby certify that I attended the deceased from Sept 30
1942 to Oct 3 1942
that I last saw him alive on 10-3-1942
and that death occurred on the date and hour stated above.

Immediate cause of death. Prematurity single birth
cong. atelectasis " " " "

Due to 159

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....
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?.....

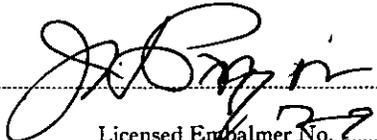
While at work? (Specify type of place) (e) Means of injury 0

23. Signature George H. Hervey (M. D. 0)
Address 1107 Bryant Bldg. Date signed 10/5/42

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. 3225

P. O. Address.....
15

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.