DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 19 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37266

Registration District No. 147 Primary Registration District No. 5569 Registrar's No. 93

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: #40 Highway Laffoon Convalescent Home-Blue Ridge Blvd (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 3

(c) City or town Kansas City 8 (If outside city or town limits, write "RURAL")

(d) Street No. 5540 Wayne Avenue (If rural, give location)

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

If yes, name country 1

3. (a) PRINT FULL NAME Mrs. Catherine Jane White

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Female 1

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 10 (Day) 1852 (Year)

8. AGE: Years 90 Months 5 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Shipley
13. Birthplace — — 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace — — 9 (City, town, or county) (State or foreign country)

16. (a) Informant —

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24, 1942 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Elmwood Cemetery

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) Oct 23 1942 (Date received local registrar) (b) Mrs A. E. Garvin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22nd year 1942 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 10-10-42, 19, to 10-22, 1942 that I last saw her alive on 10-22-42, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia — Duration 48 hrs

Due to Senility, Acidosis with Uremia. — 4 da

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

108

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 J. L. Rodgers (M. D. or other)

Address Raytown Mo Date signed 10-23-42

11-1 (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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Earle M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC Mo

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

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

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21-41
29288

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. 37266

Registration District No. 147 Primary Registration District No. 5569 Registrar's No. 93

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Catherine Jane White

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife William C. White

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

7. Birth date of deceased May (Month) 10 (Day) 1865 (Year)

8. AGE: Years 90 Months 5 Days If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business home

MOTHER FATHER

12. Name

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

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

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

Immediate cause of death	Duration
Due to	
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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature (M. D. or other)

Address Date signed

MAR 10 1945

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