

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **125**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kan City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Found Under Doctor 323- Penn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **1 year** years, months or days)

3. (a) PRINT FULL NAME **Effie Langharty**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **270**

4. Sex **Fe** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **No Record**
(Month) (Day) (Year)

8. AGE: Years **about 39** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER { 12. Name **no record**
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 **Coroner office**

(b) Address **Kan City Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **1-11-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Simple Hill**

18. (a) Signature of funeral director **Belgman, He**

(b) Address **KC Mo**

19. (a) **1-11-43** (Date received local registrar) (b) **M. M. Cororan** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Jackson**
(c) City or town **Kan City**
(If outside city or town limits, write "RURAL")
(d) Street No. **7519 - Washington**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **2**
year **1943** hour _____ minute **8:20** A.M.

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

Imm. Cause of death **Antisepsis and opsema of food**
Due to **hypertension and arteriosclerosis**
Due to **Coronary atherosclerosis**
Other conditions **Further investigation**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy **All above**

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) **123**
(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 _____

23. Signature **[Signature]** (M. D. or other) _____
Address **K.C. Mo** Date signed **1/5/43**

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

5-17-39
X32873

45
100
P

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.....

H. C. Bergman

Licensed Embalmer No.....

2041

P. O. Address.....

He No

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 125

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution: Sound Under Veaduct
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days.....)

3. (a) PRINT FULL NAME

Offie Daugherty

(b) If veteran, name war..... (c) Social Security No.....

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

MOTHER FATHER

10. Usual occupation.....

11. Industry or business.....

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) 11-3-43 (b) He Brown
(Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.?..... years.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH..... Month Jan day 2 year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I was born..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Contusions & Abrasions of head

Due to.....

Subdural + Dural Hemorrhage

Other conditions.....

(Include pregnancy within 3 months of death)

Inquest in Sept 1943

Major findings: Unable to determine cause of injuries

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.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

1042