

V. S. No. 2  
FORM-5-42  
Rev. 5-17-39  
FPI X3277

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9094  
Registrar's No. 1528

ED APR 8 1943  
Registration District No. 49

Primary Registration District No. 1002

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

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. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community no record

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. 118 1/2 Independence Avenue  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no

3. (a) PRINT FULL NAME Emerson Gunthrie

3. (b) If veteran, name war no record 3. (c) Social Security No. none

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced no record

6. (b) Name of husband or wife no record 6. (c) Age of husband or wife if alive no record years

7. Birth date of deceased no record  
(Month) (Day) (Year)

8. AGE: Years no record Months Days If less than one day hr. min.

9. Birthplace no record  
(City, town, or county) (State or foreign country)

10. Usual occupation no record

11. Industry or business

MOTHER FATHER { 12. Name no record

13. Birthplace no record  
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record  
(City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. General Hospital

17. (a) H.C. Dental College Date thereof 4-1-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo

18. (a) Signature of funeral director Snow-Mayer

(b) Address 2315 Linnwood

19. (a) 3/30/43 (b) M. D. O'Brien  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28th  
year 1943 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from 3-23-43 19   to 3-28-43 19  ;

that I last saw him in alive on 3-28-43 19  ;

and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage

Due to gja

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 work) (c) Means of injury

23. Signature Dr. M. D. O'Brien M. D. or other) Med. Dir. K.C. General Hospital  
Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**