

S. No. 2  
DOM-2-43  
5-17-43  
I X3537

20289

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2594

Registration District No. 149

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:  
3400 Garfield, /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
In this community 2 years, (Specify whether  
years, months or days)

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. 3400 Garfield,  
(If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Clarissa Belle Chrisman,

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 24 1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
88 9 13 hr. \_\_\_\_\_ min.

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

10. Usual occupation at home,

11. Industry or business X

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 Mrs. Myrtle Campbell

(b) Address 3400 Garfield

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-43  
(Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza K. C., Mo.

19. (a) 6-8-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7th  
year 1943 hour 7:00 minute 0 A. M.

21. I hereby certify that I attended the deceased from 6-1-43  
19. 6-7- 19. 43

that I last saw her alive on 6-6- 19. 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardiac Renal disease

Due to Senility 13/A

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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? \_\_\_\_\_

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

23. Signature J. J. Campbell (M. D. or other) Address 1429 Profess Bldg Date signed 6-7-43

*Proof*

Dr. James Walker

1000-1 101000-10000  
1000-10

*W. H. H. H.*

**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 *J. Blair Shippard*  
Licensed Embalmer No. *4179*  
P. O. Address *H. C. 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.