

V. S. No. 2
FORM-2-43
Re 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27268
Registrar's No. 3494

ED AUG 21 1943

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: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 hrs (Specify whether
In this community 8 hours 10 yrs
years, months or days)

3. (a) PRINT FULL NAME George Joseph Chinner
3. (b) If veteran, name war 2nd 3. (c) Social Security No. 2nd

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 16 - 1932
(Month) (Day) (Year)

8. AGE: Years 10 Months 10 Days 26 If less than one day _____ hr _____ min.

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

10. Usual occupation School Boy

11. Industry or business _____

12. Name George W Chinner

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

14. Maiden name Arlyce Hardy

15. Birthplace Fountain Colo.
(City, town, or county) (State or foreign country)

16. (a) Informant Geo W Chinner

(b) Address 416 W 59 - KC Mo

17. (a) removal (b) Date thereof 8-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn H.C.P.

18. (a) Signature of funeral director Elyar Funeral Home
(b) Address 800 Lombard Blvd H.C.

19. (a) 8-13-43 (b) P. E. Brown
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Jackson Missouri
(a) State _____ (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 416 W. 59th St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 12
year 1943 hour 9 minute 15 P. M.
21. I hereby certify that I attended the deceased from August 12 to August 12 1943
that I last saw him alive on August 12 1943
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Acute bulbar poliomyelitis

Due to _____
21

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 place)
Means of injury _____

23. Signature Dr. R. P. Thomas (M. D. or other)
Address K.C. Mo Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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. B. Longford*.....

Licensed Embalmer No. *3833*.....

P. O. Address *See Summary*.....

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.