

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27436
3573

State File No. _____
Registrar's No. _____

FILED AUG 27 1949
Registration District No. _____

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, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 511 S. Drury
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 27 years _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Frank Paul
3. (b) If veteran, name war -- no 3. (c) Social Security No. none

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mollie Paul 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased June 4, 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 2 14 hr. min.

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

10. Usual occupation Retired laborer

11. Industry or business K.C. Terminal R.R. Co.

MOTHER FATHER

12. Name Joseph Paul
13. Birthplace Missouri
(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 Mrs. Mollie Paul

(b) Address 511 S. Drury, K.C. Mo.

17. (a) Burial (b) Date thereof Aug. 19-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warrensburg, Mo.

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Indep. Ave. K.C. Mo.

19. (a) 8-18-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City, Mo. 5
(If outside city or town limits, write "RURAL") 8
(d) Street No. 511 S Drury
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 18
year 1943 hour 6 minute ▲ M.

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

Immediate cause of death Acute Pulmonary Edema
Due to Hypertrophy and dilatation of heart
Due to Carcinosis of Liver.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 124 lb
Of operations _____
Of autopsy See Above

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 A. E. Upsher (M. D. or D. O.) M.D.
Address 22 M. E. Coy 3 Date signed 8/18/43

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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.