

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 6 1944
Registration District No. 199

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10120
Registrar's No. 1167

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. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day 2 hrs.
(Specify whether years, months or days)
In this community 10 YEARS

3. (a) PRINT FULL NAME JOSEPH John Sexton
3. (b) If veteran, name war No
3. (c) Social Security No. 488-103176

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. RATE SEXTON
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased JUNE 13 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 9 Days 0
If less than one day hr. min.

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

10. Usual occupation STEAM FITTER

MOTHER FATHER

11. Industry or business
12. Name JOHN F. SEXTON
13. Birthplace MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name CECELIA LYNCH
15. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. RATE SEXTON
(b) Address 5307 ALFRED, ST. LOUIS, MO.
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof MAR. 14 1944
(Month) (Day) (Year)
(c) Place: burial or cremation ST. LOUIS, MISSOURI

18. (a) Signature of funeral director W. H. Newcomer's son
(b) Address 1401 BRUSH CREEK BLVD
19. (a) 3-14-44 (Date received local Registrar)
(b) W. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1418 Linwood
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1944 hour 1 minute 50 A. M.
21. I hereby certify that I attended the deceased from March 11 1944 to March 13 1944;
that I last saw him alive on March 13 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumococcic meningitis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations gla
Of autopsy See above

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) _____
(c) Means of injury _____
23. Signature A. E. Usher (M. D. or other) 2-13-44
Address 22 M. Way Date signed

APR 7 1944
APR 19 1944

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: *A. C. Newcomer Jr.*

Licensed Embalmer No. *4043*

P. O. Address *A. 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.