

No. 2
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10179

State File No. _____

FILED APR 7 1944

Registration District No. 177

Primary Registration District No. 1002

Registrar's No. 1347

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. 7 days

In this community 16 yrs. (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. 3116 Oak
(If rural, give location)

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

3. (a) PRINT FULL NAME Minnie Turk

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1944 hour 2 minute 30 P.M.

4. Sex Fe 5. Color or race Wh

6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Albrine

6. (c) Age of husband or wife if alive. 65 years

7. Birth date of deceased Jan 7th 81
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 16, 1944, to March 23, 1944;
that I last saw her alive on March 23, 1944;
and that death occurred on the date and hour stated above.
Immediate cause of death Possible meningitis
 pending further examination

8. AGE: Years Months Days If less than one day
63 2 16 _____ hr. _____ min.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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

Major findings:
Of operations _____

10. Usual occupation Housewife

Of autopsy See above

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

11. Industry or business _____

12. Name Jacob Stoffle

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

14. Maiden name Gertrude Lovie

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Albrine Turk

(b) Address 3116 Oak

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? _____

17. (a) Burial (b) Date thereof Mar 25 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Pk

18. (a) Signature of funeral director [Signature]

(b) Address 7401 Wornall Rd

23. Signature A. E. Upshere, M.D.
28 M. Coy.
Date signed 3-24-44

19. (a) 3-25-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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

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. Pauline Rose*.....

Licensed Embalmer No. *2810*.....

P. O. Address *P. O. Box*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1347

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
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 _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME: Minnie Turk
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

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

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 16, 1944 (b) T. E. Brown
(Date recorded local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 23
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Possible Meningitis
Pending further investigation
Due to: Blood cultures reveal hemolytic streptococcus
Other conditions: _____
(Include pregnancy within 3 months of death)
Major findings: Septicemia 246
Of operations: Leva -
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? _____

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

23. Signature: A. E. Upsher (M. D. or other) _____
Address: Mo. Date signed _____

SUPPLEMENTARY

10179