

U.S. No. 2
DOM-5-43
Rev. 5-17-39
No. 1 X36671

State File No. 38015
Registrar's No. 552

FILED NOV 28 1944
Registration District No. 2001

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Freeman Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Four minutes
(Specify whether years, months or days)

In this community Nov. Resident

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Cherokee

(c) City or town Galena
(If outside city or town limits, write "RURAL")

(d) Street No. Wilshire St R1
(If rural, give location)

(e) Citizen of foreign country? Yes (No) No
If yes, name country U.S.

3. (a) PRINT FULL NAME Cynthia Kathryn Drake

3. (b) If veteran, name war No 3. (c) Social Security No. 710

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Willard Drake 6. (c) Age of husband or wife if alive Eleven years

7. Birth date of deceased March unknown 1876
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14 year 1944 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct 17 1944 to Nov 14 1944 that I last saw him alive on Nov 14 1944 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>-</u>	<u>-</u>	hr. _____ min. _____

Due to Chronic Degenerative Heart

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN 92d

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Housekeeper

11. Industry or business at home

12. Name Starvo Jones A

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

14. Maiden name unknown

15. Birthplace Tenn. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mildred Bradshaw
(b) Address Galena Kan.

17. (a) Removal (b) Date thereof Nov. 14-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galena - Kan.

18. (a) Signature of funeral director Frank Allison
(b) Address Galena, Kan.

19. (a) 11-15-44 (b) Gertie S. Smith
(Date received local registrar) (Registrar's signature)

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) _____

(Specify type of place) _____ Means of injury while at work

23. Signature 92d Date signed Nov 15 1944

1204

44-11-950

STATE OF KANSAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

STATE OF KANSAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

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

Removed to Galena Kan type Emb. Registered Apprentice No. _____

working under my personal supervision.

Signed *Frank Allison* _____

Kan Licensed Embalmer No. *1321*

P. O. Address *Galena Kan*

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.