S. No. 2
0M—2-43
v. 5-17-39
I X35097

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 4 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40425

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5239

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C., Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital # 10 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months (Specify whether

In this community 4 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town K.C. Mo (If outside city or town limits, write "RURAL")

(d) Street No. 1808 Montgall (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Williams, Sarah

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Thomas

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

7. Birth date of deceased Sept. (Month) 17, (Day) 1884 (Year)

8. AGE: Years 60 Months 3 Days 6 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name James Kennedy
13. Birthplace (City, town, or county) Ind. (State or foreign country)

MOTHER
14. Maiden name Mary Casky
15. Birthplace Ray Co., (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Tillie Gleason

(b) Address Kansas City, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 12-26-44 (Month) (Day) (Year)

(c) Place: burial or cremation South Point

18. (a) Signature of funeral director Brothers Good

(b) Address Orrick, Mo.

19. (a) 12-23-44 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 year 1944 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 Ruptured Gallbladder

Due to Cholelithiasis

Due to

Other conditions (Include pregnancy within 3 months of death) 12 Lo

Major findings:
Of operations

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) MD.

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Cortland Minor

Licensed Embalmer No. 3414

P. O. Address Richmond, Ind.

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.