

S. No. 2
FORM-2-43
rv. 5-17-39
1 X35697

5135

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 3 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 739

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:
Vinyard Park Hospital
(If not in hospital or institution, write street number or location)

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

In this community 32 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

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

(d) Street No. 1035 1/2 Minnesota Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Minnie E. Eddy

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13th
year 1945 hour 6 minute A. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife T. N. 6. (c) Age of husband or wife if alive 1891 years

7. Birth date of deceased May 19, 1890
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 14 1945 to Feb 8 1945
that I last saw him alive on Feb 8
and that death occurred on the date and hour stated above.

8. AGE: Years 53 ~~54~~ Months 8 Days 25 If less than one day hr. min.

9. Birthplace Don't know Illinois
(City, town, or county) (State or foreign country)

Immediate cause of death Gas an any thrombosis

Due to Sole blood coagulation 14 days before

Due to infected Sole blood on stomach

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Housework

11. Industry or business at home

12. Name Joseph Vandagniff

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

14. Maiden name Alice Dodge

15. Birthplace don't know
(City, town, or county) (State or foreign country)

Major findings: Of operations 9/4

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Doris Cramer

(b) Address 1035 1/2 Minn. Ave. K. C. Ks.

17. (a) Removal (b) Date thereof 2/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope K. C. Ks.

18. (a) Signature of funeral director Rev. J. Porter

(b) Address 915 N. 10th St. K. C. Ks.

19. (a) 2-14-45 (b) D. E. Brown
(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? _____

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

23. Signature Wm. Wheeler (M. D. or other) 1945
Address 752 9th Ave Date signed 2/15

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

MAR - 8 1945

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

Howard L. Porter

Registered Apprentice No.

working under my personal supervision.

Signed

Howard L. Porter

Licensed Embalmer No. **3751**

P. O. Address **915 N. 10th K.C.Ks.**

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.