

U.S. No. 2  
OM-5-43  
7-5-17-39  
1 X38671

**FILED MAR 29 1945**  
Registration District No. **1945**

Primary Registration District No. **1002**

Registrar's No. **1225**

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:  
2711 Forest  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 4 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **40**

(c) City or town Kansas City **13**  
(If outside city or town limits, write "RURAL") **8**

(d) Street No. 2711 Forest  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bertha A. Raper

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. #unk.

4. Sex Female 5. Color or race wh

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

6. (b) Name of husband or wife Wayland V Raper 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 10 15 1905  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15  
year 1945 hour 10<sup>30</sup> minute 0 M.

21. I hereby certify that I attended the deceased from 1-26-43  
19\_\_\_\_ to March 15 1945  
that I last saw h. alive on March 15 1945  
and that death occurred on the date and hour stated above.

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

39 5 0 hr. min.

Immediate cause of death Carcinoma of the cervix Duration 9-10 Mos

Due to \_\_\_\_\_

Due to 480

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Tracy Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Pratt & Whitney

11. Industry or business Air Craft

MOTHER FATHER { 12. Name Unknown / Gadd

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

14. Maiden name Unknown

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

Major findings: Carcinoma of cervix PHYSICIAN \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Wayland V Raper

(b) Address 2711 Forest

17. (a) Reinterred (Burial, cremation, or removal) (b) Date thereof 2/16/45  
(Month) (Day) (Year)

(c) Place: burial or cremation Tracy Kansas

18. (a) Signature of funeral director Brown - Mayberry

(b) Address 2315 Linwood

19. (a) 3-16-45 (Date received local registrar) (b) T. E. Brown (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 T. E. Brown (M. D. or other) MD

Address Kansas City, Mo. Date signed 3/16/45

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

1730 Prof Bg

Form 1009

**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 \_\_\_\_\_

*Ray C. Snow*

Licensed Embalmer No. \_\_\_\_\_

*2560*

P. O. Address \_\_\_\_\_

*H C MD*

**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. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1225

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: .....  
(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 Bertha A. Raper (not Roper)

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 .....

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 Wayland W. Raper

(b) Address 2710 Forest

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) 3-16-45 (b) Geraldine Holmes (Registrar's signature)

(Date received local registrar)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: 1945 Month March Day 15  
year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19.....  
that I last saw him/her alive on ..... 19.....  
and that death occurred on the date and hour stated above.  
(Immediate cause of death) ..... Duration

Due to .....

Due to .....

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

Major findings:  
Of operations .....

Of autopsy .....

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)

(b) 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 .....

Address ..... (M. D. or other) .....

Date signed .....

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

SUPPLEMENTARY

8764