

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12100
12100
Registrar's No. 1761

FILED MAY 3 1945

Registration District No. 179

Primary Registration District No. 1002

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: General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3-18-45-3-20-45
(Specify whether years, months or days)

In this community unknown

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. Westport & Mill
(If rural, give location)

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

3. (a) PRINT JOHN RIVERS
FULL NAME

3. (b) If veteran, name war Don't know 3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife Don't know 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 12 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	2	8	_____ hr. _____ min.

9. Birthplace Lee County Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Don't know

13. Birthplace _____

14. Maiden name Don't know

15. Birthplace _____

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 4-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem.

18. (a) Signature of funeral director W. J. Applin

(b) Address _____

19. (a) 4-19-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20
year 1945 hour 2:45 minute A M.

21. I hereby certify that I attended the deceased from March 18 19 45 to March 20 19 45
that I last saw h. im alive on March 20 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Occlusion--
Arterio Sclerosis

Due to _____

Due to _____

Other conditions 838
(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)

(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 S. A. Holmes (M. D. or other)
Address Dr. Holmes #2-600 E. 22 Date signed 3-23-45

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

8
3
8

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.....

Licensed Embalmer No. 2710

P. O. Address.....

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.