

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1255W
Registrar's No. 1660

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Polyclinic Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 3 hrs
In this community 12 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kanso (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2337 Fairmount
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Amelia Vasquez
(b) If veteran, name war no
(c) Social Security No. 510-22-8706

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 6
Year 1945 hour 3 minute 0 P. M.

4. Sex Female
5. Color or race Mexican
6. (a) Single, widowed, married, divorced Single
(b) Name of husband or wife
(c) Age of husband or wife if alive years 29 months 1928
(Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years Months Days If less than one day
17 1 27 hr. min.

Cause of death unknown
pending investigation
Due to _____
Due to _____

9. Birthplace Mitchell Nebraska
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy See above

10. Usual occupation machine operator

11. Industry or business Continental Can Co.

MOTHER FATHER
12. Name Jose Vasquez
13. Birthplace Mexico
(City, town, or county) (State or foreign country)
14. Maiden name Maria Cortez
15. Birthplace Mexico
(City, town, or county) (State or foreign country)

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

16. (a) Informant Jose Vasquez
(b) Address 837 South 6th K.P. Kansas

17. (a) Burial (b) Date thereof 4-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Calvary

18. (a) Signature of funeral director Blum & Wacker
(b) Address 733 Monitor Place

19. (a) 4-12-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

Signature J. H. Overman (M. D. official)
Address 534 Ralls Kansas Date signed 4/11/45

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

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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1660

Registration District No. 149 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:
Polyclinic Hosp.
(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 Amelia Vasquez

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 _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 4-12-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

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: Month April Day 6
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
Deputy Coroner _____
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

acute circulatory failure
(etiology unknown)
Due to acute pulmonary edema and
congestion

Due to _____

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

Major findings: 109:1
Of operations _____

Of autopsy see above

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) (e) Means of injury _____

23. Signature P. H. Owens (M. D. or other) _____

Address 1034 Rialto Bldg Date signed 4-11-45

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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