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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 30 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22873

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2995

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 2111 Brooklyn Ave. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) Three weeks

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2111 Brooklyn (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Emma Copper

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex Female

5. Color or race Negro

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

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 (Month) about (Day) 1875 (Year)

8. AGE: Years about 70 Months — Days — If less than one day hr. min.

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

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Wm Bly
13. Birthplace Don't Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant C. D. Tiers

(b) Address 2117 Prospect

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem

18. (a) Signature of funeral director West Appleby Jones City

(b) Address

19. (a) 7-18-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1945 hour minute 12:15 A.M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h above on Deputy Coroner , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction (n. m. o.)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 12 2 b

Major findings:
Of operations
Of autopsy Insp History

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 L. P. Richardson (M. D. or other)

Address 1832 Vine Date signed 7-17-45

(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 C. H. West

Licensed Embalmer No. 2710

P. O. Address K. C. MO.

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.