

S. No. 2
M-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40236**
Registrar's No. **5185**

Registration District No. **149**

Primary Registration District No. **1002**

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

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: **1000 Sarfield**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 yrs** (Specify whether years, months or days)
In this community **18 yrs**

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. **1000 Sarfield**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME

Harold Rawlings

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **M**

5. Color of race **W**

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

6. (b) Name of husband or wife **Nazel Rawlings**

6. (c) Age of husband or wife if alive **43** years

7. Birth date of deceased **Dec 6 1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	56	0	9	hr. min.

9. Birthplace **Ill 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter maker**

11. Industry or business **Self**

MOTHER, FATHER

12. Name **Thomas Rawlings**

13. Birthplace **no record**
(City, town, or county) (State or foreign country)

14. Maiden name **no record**

15. Birthplace **no record**
(City, town, or county) (State or foreign country)

16. (a) Informant **Nazel Rawlings**

(b) Address **1000 Sarfield**

17. (a) **Burial** (b) Date thereof **Dec-18-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **Mrs C. L. Foster**

(b) Address **918 Brooklyn**

19. (a) **12-17-45** (b) **Sheldine Ho**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **15** year **1945** hour **10** minute **30** A.M.

21. I hereby certify that I attended the deceased from **June 1, 1945** to **Dec 15**, 1945, and that I last saw him alive on **December 14**, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death **atypical pneumonia**
Bronchial

Duration **1 week**

Due to
Due to
Other conditions **Bronchitis with Emphysema**
(Include pregnancy within 3 months of death)

Major findings:
Of operations

107

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) (c) Means of injury
Signature **Saunder** (M. D. or other) **M.D.**
Address **221 Plaza Medical Bldg** Date signed **12-15-45**

Kans. city, mo.

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.....

JOE B. Yoder

Licensed Embalmer No. *4173*

P. O. Address *918 Brooklyn*

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.