

U.S. No. 2
FORM-5-43
REV. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40257**
Registrar's No. **5140**

FILED DEC 28 1945
Registration District No. **1002**

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

(c) Name of hospital or institution:
Childrens Mercy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days - 7 Hrs.
(Specify whether years, months or days)

In this community 5 Days, 7 Hrs.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Barbara Jean Senogham

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex E / 5. Color or race W

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 30 1939
(Month) (Day) (Year)

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

5 8 11 13 hr. _____ min.

9. Birthplace Holden, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business

MOTHER FATHER {

12. Name Walter Lee Senogham

13. Birthplace Foster, Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Artis Crowley Senogham

15. Birthplace Knob Noster, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Father

(b) Address Holden, Mo.

17. (a) Removal (b) Date thereof 12-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Holden, Mo.

18. (a) Signature of funeral director Samuel B. Roff

(b) Address Holden, Mo.

19. (a) 12-13-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 51

(c) City or town Holden, Mo. RD 274 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 13
year 1945 hour 9:00 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
Pathologist

that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Bronchial Pneumonia
Left lower lobe

Due to Diabetes Mellitus

Due to _____

Other conditions Cerebral Convulsion
(Include pregnancy within 3 months of death)

Duration _____

Major findings: _____

Of operations 1 globe - 5

Of autopsy Bronchial Pneumonia
Left lower lobe & Cerebral Convulsion

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) Accident

(b) Date of occurrence Dec. 1, 1945 51

(c) Where did injury occur Holden, Johnson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, or in industrial place, or in public place?
at home
Where (Specify type of place) _____
(Specify type of means of injury) fall

23. Signature Edward Lewis (M. D. or other) _____
Address St. Lukes Hospital Date signed 13-Dec

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

Samuel B Popper

Licensed Embalmer No. *4444*

P. O. Address. *Holder 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.