

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1326
Registrar's No. 113

FILED JAN 31 1948

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:
917 Grand Ave 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1029 E 12th
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph B Domars
(b) If veteran, name war Do not know
(c) Social Security No. Do not know

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 5
year 1948 hour 12 minute 10 P.M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____,
that I last saw h_____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced Do not know
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

Duration
Immediate cause of death Coronary sclerosis
Due to arterio sclerosis

7. Birth date of deceased: Jan 31 1896
(Month) (Day) (Year)
8. AGE: Years 49 Months 11 Days 4
If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) 940
Major findings:
Of operations _____
Of autopsy no
Histology & Inspection

9. Birthplace Do not know
(City, town, or county) (State or foreign country)
10. Usual occupation Businessman
11. Industry or business _____

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

MOTHER FATHER
12. Name Do not know
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name Do not know
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Coroner office
(b) Address 126 W 1st
17. (a) Burial (b) Date thereof Jan 1-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation mt Hope Church

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 _____

18. (a) Signature of funeral director Pasantino
(b) Address 126 W 1st
19. (a) 1-9-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature James P. Miller (M. D. or other) Coroner
Address 1424 1/2 W 1st Date signed 1-5-48

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.....

Francis Walton

Licensed Embalmer No. *2744*

P. O. Address *K C Rd*

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.