

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

049400

State File No. \_\_\_\_\_

FILED MAR 18 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1165

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:  
General Hospital No. 1  
(If not in hospital of institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 days  
(Specify whether years, months or days)  
In this community 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 215 So. Indiana 8  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jessie Foster

3. (b) If veteran, name war No 3. (c) Social Security No. Yes Unknown

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jimmie Foster 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 2, 1926  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>19</u>	<u>10</u>	<u>4</u>	hr. _____ min.

9. Birthplace Excelsior Springs, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business Claude O'Dell

12. Name Claude O'Dell

13. Birthplace Ray County Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Pearl Crawford

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

16. (a) Informant Jessie L. O'Dell

(b) Address Excelsior Springs, Mo.

17. (a) burial (b) Date thereof 3/8/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Enon Cem. Ray Co. Mo.

18. (a) Signature of funeral director Hope Funeral Home

(b) Address Excelsior Springs, Mo.

19. (a) 3-9-46 (b) Seraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6  
year 1946 hour 6 minute 55 P.M.

21. I hereby certify that I attended the deceased from Feb. 20, 1946, to March 6, 1946;  
that I last saw her alive on March 6, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute disseminated lupus erythematosus

Due to \_\_\_\_\_  
Due to 153' 2"  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 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) \_\_\_\_\_  
(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 \_\_\_\_\_  
23. Signature Clark W. Sedgwick (Date signed) 3-9-46  
Address Med. Dir. Gen'l Hosp. (City or town) (County) (State) \_\_\_\_\_

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

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

8326

*John J. ...*

**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 *James A. Males*

Licensed Embalmer No. *3396*

P. O. Address *Ed Spring M*

**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.**