

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9605
3606

State File No. _____
Registrar's No. 1398

Registration District No. 149 Primary Registration District No. 1002

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:
Neurological Hospital - 2625 Paseo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days
(Specify whether
In this community 10 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County 999
(c) City or town Independence Kansas
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME Homer Page
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex Male 5. Color or race Wh
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edna Page
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Jan 19 1878
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 5
If less than one day hr. _____ min. _____

9. Birthplace Sutton Neb
(City, town, or county) (State or foreign country)
10. Usual occupation Retired

11. Industry or business _____
12. Name Arthur E Page
13. Birthplace Canada
(City, town, or county) (State or foreign country)
14. Maiden name Sarah E Barr
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Helen Jacobs
(b) Address 4606 Olive St
17. (a) Burial (b) Date thereof 3-23-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Independence KS
18. (a) Signature of funeral director H. W. H. ...
(b) Address 1401 Break Creek
19. (a) 3-23-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 24th
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 3-13-46
3-24, 1946 to _____, 19____;
that I last saw him alive on 3-24, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure
Due to Chronic Nephritis
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____
13/15

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 C. J. Parker (M. D. or other) _____
Address 2625 Paseo, K.C. Mo Date signed 3-24-46

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

MOTHER FATHER

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

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.....

Melvin Miller

Licensed Embalmer No. *4407*

P. O. Address.....

Kansas City, 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.