

No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23572

FILED JUL 31 1946

Registration District No. 799

Primary Registration District No. 1003

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

Registrar's No. 3083

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: H.C. The Hosp. O.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days  
(Specify whether years, months or days)

In this community 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 2411 E. 16th 8  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Drummer, Ruth

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

3. (c) Social Security No. 514098708

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12  
year 1946 hour 7:58 minute 35 A.M.

4. Sex F 3

5. Color or race negro

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: Jan. 12 1918  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-21 1946 to 7-12 1946  
that I last saw her alive on 7-12-46  
and that death occurred on the date and hour stated above.

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

28 6 0 hr. min.

Immediate cause of death: Pulmonary Tuberculosis 2 mo approx

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace: Guthrie Okla  
(City, town, or county) (State or foreign country)

Other conditions: Tuberculosis Eulentic 1 mo

(Include pregnancy within 3 months of death)

10. Usual occupation: Fountain Girl

11. Industry or business: Harvey's Restaurant

Major findings: 1361

Of operations \_\_\_\_\_

Of autopsy: Same

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name: Governor Barber Rayburn

13. Birthplace: Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name: Curra E. Potts

15. Birthplace: Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant: H.C. The Hosp

(b) Address: K.C. Mo.

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof: 7-15-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery K.C.K.

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director: Nathan Shatkin

(b) Address: 1520 N. 5th Street

19. (a) 7-15-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

23. Signature: J. L. Rodgers (M. D. or other) M.D.  
Address: Kansas City Mo. Date signed: 7-12-46

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

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 *Nathan Whatchee*.....

Licensed Embalmer No. *2700*.....

P. O. Address. *1520 N. 5<sup>th</sup> St. K.C.*.....

**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.