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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

33449

FILED OCT 28 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4323

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: St Marys 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 weeks
(Specify whether

In this community Most of his life
years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24

(c) City or town R.R.8 North Kansas City 2
(If outside city or town limits, write "RURAL")

(d) Street No. R.R.8 1
(If rural, give location)

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

If yes, name country no

3. (a) PRINT FULL NAME Jacob H. Blagrave

3. (b) If veteran, name war no 3. (c) Social Security No. 495-07-2560

4. Sex: Male 5. Color or race: white 6. (a) Single, widowed, married, divorced, widowed: 2 divorced, widowed

6. (b) Name of husband or wife: Laura E. Blagrave 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: Feb 11 1888
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>8</u>	<u>3</u>	hr. min.

9. Birthplace: Natoma Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation: Linotype Operator

11. Industry or business: _____

12. Name: Emmette Blagrave 9

13. Birthplace: unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name: Emma Boyer

15. Birthplace: unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant: Laura E. Blagrave

(b) Address: R.R.8 N.K.C. Mo

17. (a) Removal (b) Date thereof: Oct 16 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: East Slope N.K.C. Mo

18. (a) Signature of funeral director: Morton-Smith

(b) Address: 832 Armour Ed N.K.C. Mo

19. (a) 10-15-46 (b) Sheldine Helme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14 year 1946 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from September 7 1946 to Oct 14 1946.

that I last saw him alive on Oct 13 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage

Due to: lung abscess, right lower lobe secondary to

Due to: Carcinoma of lung

Other conditions: 478
(Include pregnancy within 3 months of death)

Major findings: lung abscess
Of operations

Of autopsy: Carcinoma of lung

Duration

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) _____

(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) (c) Means of injury _____

23. Signature: Myron C. Myre (M. D. or other)

Address: 618 Poplar Bldg, KC Mo Date signed: 15 Oct 46

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

MOTHER FATHER

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.....

Thomas Smith

Licensed Embalmer No. *3928*

P. O. Address *North Kansas City*

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.