

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 12 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4586

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:
4234-SOUTH BENTON
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 86 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 4234-SOUTH BENTON
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. S. CAROLINE RAMP

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 29TH
year 1946 hour 10 minute 35 A. M.

21. I hereby certify that I attended the deceased from 10-15-46
to 10-29-46, 19____, to 10-29-46, 19____;
that I last saw her alive on 10-29-46
and that death occurred on the date and hour stated above.

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MR. JEREMIAH E RAMP

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

7. Birth date of deceased NOVEMBER 23 1859
(Month) (Day) (Year)

Immediate cause of death Carcinoma of sigmoid & liver metastasis

Duration ?

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>11</u>	<u>6</u>	hr. _____ min. _____

Due to _____

Due to _____

9. Birthplace ANDERSON COUNTY INDIANA
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) 410/2

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER {

12. Name ISSAC BOOCO

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

14. Maiden name CATHERINE WINCH

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. E. E. Paige

(b) Address 4-22 Lake Latawana

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) BURIAL (b) Date thereof OCT. 31-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

(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? _____

18. (a) Signature of funeral director D. H. Newcomer, Sr.

(b) Address 1401-BRUSH CREEK BLDG.

19. (a) 10-31-46 (b) Theraldne Helms
(Date received from registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury 11

23. Signature Graham Owens (M. D. optional)
Address 906 Grand KCMO Date signed 10-30-46

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

33

DEC 30 1946

Paula Bell

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 Emile M. Colburn

Licensed Embalmer No. 3506

P. O. Address. K C 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.