

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 4 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36971**
Registrar's No. **4830**

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: 3240 Brighton.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Lifetime 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. 3240 Brighton
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mr. Charles Andrew Gove

3. (b) If veteran, name war none 3. (c) Social Security No. None

4. Sex male 5. Color or race White 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 October 31 1917
(Month) (Day) (Year)

8. AGE: Years 29 Months 0 Days 14 If less than one day, hr. _____ min. _____

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

10. Usual occupation none

11. Industry or business _____

12. Name Emiel Gove

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

14. Maiden name Maggie Kenniley

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

16. (a) Informant Emiel Gove

(b) Address 3240 Brighton
17. (a) burial (b) Date thereof 11/18/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Gates Funeral Home
(b) Address 1901 Olive Blvd. K.C.K.

19. (a) 11-18-46 (b) Steadline Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 15
year 1946 hour 9:15 PM minute _____ M.

21. I hereby certify that I attended the deceased from 11/15/46 only
I _____, 19____ to _____, 19____;
that I last saw him _____ alive on last call D.O.A., 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Complete Coronary Occlusion
Due to Paralysis, Arteriosclerosis, Injured when child, Embolisms
Due to _____
Other conditions Tuberculosis
(Include pregnancy within 6 months of death)
Major findings: Had just for years
Of operations _____
Of autopsy D.O.A. by Coroner's Office

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) (e) Means of injury _____
23. Signature Dr. A. David Andrist (M. D. or other) D.C.
Address 4000 Tracy Date signed 11/18/46

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

MOTHER FATHER

Dr. A. A. ... 4000 Tracy
No 7493

2-27-6

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 D. Rose Blanford
Licensed Embalmer No. 4015
P. O. Address 414 State Line

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.