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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED DEC 19 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 5067

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

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:  
RESEARCH HOSPITAL 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 WEEKS  
(Specify whether)

In this community 38 YEARS  
years, months or days)

3. (a) PRINT FULL NAME MR. HUBERT LESTER SHOUSE

3. (b) If veteran, name war No

3. (c) Social Security No. 486-07-4534

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. BETTY SHOUSE 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased JANUARY 25 1908  
(Month) (Day) (Year)

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

38	10	5	hr. min.
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9. Birthplace CLAY COUNTY MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation REFRIGERATOR ENGINEER

11. Industry or business \_\_\_\_\_

12. Name WILLIAM SHOUSE

13. Birthplace CLAY COUNTY MISSOURI  
(City, town, or county) (State or foreign country)

14. Maiden name LYDIA MILLER

15. Birthplace PLATTE COUNTY MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. BETTY SHOUSE

(b) Address 3211 AGNES AVENUE

17. (a) BURIAL (b) Date thereof DEC-2-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEM.

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

(b) Address 1401 BRUSH CREEK BLD.

19. (a) 12-2-46 (b) Thalidine Holmes  
(Date received local registrar) (Registrar's signature)

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. 3711 AGNES AVENUE  
(If rural, give location)

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 30<sup>TH</sup>  
year 1946 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from Nov. 1  
1946, to Nov. 30, 1946  
that I last saw him alive on Nov. 29, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolic - Lung & Brain

Due to Retinitis tear myo-symphosarcoma

Duration minutes  
month

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 46 hr

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

Of autopsy Pulm. Embol.  
Retinitis tear

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 \_\_\_\_\_

Signature Frank B. ... (M. D. or other) M.D.

Address 921 1/2 Pk. Bldg. K.C. Mo. Date signed 11-30-46

2130-5:30

**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.**