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DEPARTMENT OF HEALTH
 FILED JAN 17 1947
 MISSOURI DEPARTMENT OF HEALTH

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 991
 Registrar's No. 19

Registration District No. 199 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:
General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day 11 hrs.
 (Specify whether years, months or days) 60 years.

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. 1108 Troost
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country ✓

3. (a) PRINT FULL NAME Thomas Britt
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 2
 year 1947 hour 9 minute 25 P. M.

4. Sex male 5. Color or race W.
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Effie Britt
 6. (c) Age of husband or wife if alive ✓ years
 7. Birth date of deceased April 10 1881
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 1 1947 to Jan. 2 1947
 that I last saw him alive on Jan. 2 1947
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>8</u>	<u>22</u>	<u>✓</u> hr. <u>✓</u> min.

Immediate cause of death:
Ruptured aneurysm left ventricle
(non luetic)
 Due to pneumonia (unqualified)
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

9. Birthplace Paradise Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Retired Salesman

PHYSICIAN
 Major findings:
 Of operations g3d
 Of autopsy None
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business ✓
 12. Name William Britt
 13. Birthplace Springfield Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Sophia Fegert
 15. Birthplace Paradise Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Louis Edward Britt
 (b) Address 1208 E. 23rd North Kansas City
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 1947
 (Month) (Day) (Year)
 (c) Place: burial or cremation Paradise 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?
 While at work? _____ (Specify type of place)
 (e) Means of injury ✓

18. (a) Signature of funeral director Morton Smith
 (b) Address North Kansas City Mo.
 19. (a) 1-4-47 (Date received local Registrar)
 (b) Seraldine Holmes (Registrar's signature)

23. Signature W. W. Hart (M. D. or other)
 Address Med. Dir. Gen'l Hosp. Date signed 1-3-47

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

Dr. Vick

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 *Leon O Smith*

Licensed Embalmer No. *3928*

P. O. Address *North 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.