

No. 2
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5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1083

State File No. _____

FILED FEB 11 1947
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 473

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 #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
In this community 4 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. 1304 E. 16th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ida Evans

3. (b) If veteran, name war No 3. (c) Social Security No. Unk.

4. Sex Female 5. Color or race Negor
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife UNKNOWN
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 6 1900
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>0</u>	<u>25</u>	hr. min.

9. Birthplace Bastrop County Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Maid

11. Industry or business _____

12. Name Ben Robinson

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

14. Maiden name Pauline Johnson

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

16. (a) Informant Lillian Willis

(b) Address 864 Ohio, Kansas City, Kansas

17. (a) Removal (b) Date thereof 2/1/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fort Worth, Texas

18. (a) Signature of funeral director Watkins Bros.

(b) Address 1729 Lydia Avenue

19. (a) 2-1-47 (b) Geraldine Holman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31st
year 1947 hour 12 o'clock Noon minute _____ M.
21. I hereby certify that I attended the deceased from January 21
1947 to January 31 1947
that I last saw her alive on January 31 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis Duration _____
(etiology undetermined) (*non epidemic*)

Due to Brain Abscess

Due to old fracture of skull
(*more than 1 yr. ago*)

Other conditions Latent syphilis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other)

Address Gen. Hosp. #2 Date signed _____

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

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.....

J. Jerome Manlove

Licensed Embalmer No. *3994*

P. O. Address. *2503 Highland*

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.