

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 5 1947
199

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1245
Registrar's No. 362

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. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 DAYS
(Specify whether years, months or days)
In this community 3 YRS.

3. (a) PRINT FULL NAME MILLIE MOSES
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex FEMALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife UNKNOWN 6. (c) Age of husband or wife if alive years
7. Birth date of deceased AUGUST 9 20, 25, 1897-1897
(Month) (Day) (Year)

8. AGE: Years 49 Months 5 Days 5 If less than one day hr. min. 32 3 28

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

10. Usual occupation HOUSEWORK

11. Industry or business

MOTHER FATHER
12. Name ROBERT KNIGHT
13. Birthplace LOUISIANA
(City, town, or county) (State or foreign country)
14. Maiden name CLORY GASTON
15. Birthplace LOUISIANA
(City, town, or county) (State or foreign country)

16. (a) Informant MONROE WASHINGTON (SON)
(b) Address 2800 PARK

17. (a) Removal (b) Date thereof 1-26-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Minden, La.

18. (a) Signature of funeral director Adkins Bros.
(b) Address 2000 E. 12th St. C. Mo.

19. (a) 1-25-47 (b) Seraldine 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. 2800 PARK
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 23,
year 1947 hour 10: minute 45 A.M.
21. I hereby certify that I attended the deceased from JANUARY
16, 1947, to JANUARY 23, 1947
that I last saw her alive on JANUARY 23, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death UREMIA Duration _____

Due to ARTERIOSCLEROTIC NEPHRITIS
GENERALIZED ARTERIOSCLEROSIS

Due to HYPERTENSIVE HEART DISEASE

Other conditions LATENT SYPHILIS
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 30g
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) Means of injury _____
23. Signature [Signature] (M. D. or other) M. D.
Address GENERAL HOSPITAL NO. 2 Date signed 1-24-47

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

W.C. Southern

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 A. T. Moore

Licensed Embalmer No. 948

P. O. Address.....

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.