

FILED APR 28 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13416

State File No.

1775

Registration District No.

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 2nd & Grand St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Unknown years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town K.C. (If outside city or town limits, write "RURAL")  
(d) Street No. 514 1/2 Main (If rural, give location)  
(e) Citizen of foreign country? Unknown (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

JOHN DORE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. Unknown

4. Sex Mo

5. Color or race W

6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

Unknown  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

app 63

hr. min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country) 9

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

9

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant Coroner's Office

(b) Address K.C. Mo

17. (a) Anatomical  
(Burial, cremation, or removal)

(b) Date thereof 4/19/47

(Month) (Day) (Year)

(c) Place: burial or cremation K.C. College of Osteopathy

18. (a) Signature of funeral director Subeta Funeral Home

(b) Address City

19. (a) 4-19-47  
(Date received local registrar)

(b) Geraldine Palmer  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 14  
year 47 hour 10 minute 20 P. M.

21. I hereby certify that I attended the deceased from Crown, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death

Crush amputation of both legs  
Due to shock  
A. R. Trauma

Due to train & pedestrian

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 169-8  
30

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 4-14-47 1213  
(c) Where did injury occur? K.C. Jackson Dist  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no

(e) Means of injury A.R. Trauma

23. Signature J. M. Miller (M. D. or other) 3

Address 1424 Jay St Date signed 4-17-47

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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..... *Harry Burdman*  
Licensed Embalmer No..... *2041*  
P. O. Address..... *Kan 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.**