

S. No. 2
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5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17350**

FILED MAY 20 1947
Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **1992**

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:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **45 MINS.** (Specify whether
In this community **4 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON 48**
(c) City or town **KANSAS CITY 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **1522 TROOST 8**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **JANETTE CLARK**
(b) If veteran, name war **No**
(c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **APRIL** day **30**
year **1947** hour **1:** minute **30** A. M.

4. Sex **FEMALE** 5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **SINGLE**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **APRIL 15, 1943**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **APRIL 29, 1947, to APRIL 30, 1947**
that I last saw h **ER** alive on **APRIL 30, 1947**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
4 0 15 hr. min.

Immediate cause of death **ASPHYXIA** Duration

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)

Due to **Acute membranous tracheitis (and bronchitis)**

10. Usual occupation **Child**

Due to _____

11. Industry or business

Other conditions **106 a**
(Include pregnancy within 3 months of death)

12. Name **CLAUDE CLARK**

Major findings: Of operations _____

13. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)

Of autopsy **SAME AS ABOVE**

14. Maiden name **PHYLLIS HOLLOWAY**

Underline the cause to which death should be charged statistically.

15. Birthplace **TOPEKA KANSAS**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **PHYLLIS CLARK (MOTHER)**
(b) Address **1522 TROOST**

(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? _____

17. (a) **Burial** (b) Date thereof **5/5/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) Place: burial or cremation **Lincoln Cemetery**

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

(b) Address **1729 Wythe Avenue**
19. (a) **5-5-47** **Shaldine Holme**
(Date received local registrar) (Registrar's signature)

23. Signature **Frank [Signature]** (M. D. or other M.D.)
Address **GENERAL HOSPITAL NO. 2** Date signed **4/30/47**

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. James Marlow*
Licensed Embalmer No. *3994*

P. O. Address *2683 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.