

17517

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 20 1947

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 2003

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 11 Hrs. 50 Mins.
(Specify whether
In this community 25 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48
(c) City or town KANSAS CITY 2
(If outside city or town limits, write "RURAL")
(d) Street No. 2016 E. 16TH ST. 8
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME

ROBERT Mc COY

3. (b) If veteran, name war No

3. (c) Social Security No. unknown

4. Sex MALE 2
5. Color or race NEGRO

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

6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased NOVEMBER 21, 1910
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 5 8 hr. min.

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

10. Usual occupation LABORER - (COMMON)

11. Industry or business

12. Name JOHN E. Mc COY

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

14. Maiden name IDA MILES

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

16. (a) Informant JOHN E. Mc COY

(b) Address 1522 LYDIA

17. (a) Burial (b) Date thereof 5/6/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1729 Lydia Avenue

19. (a) 5-5-47 (b) [Signature] (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 29, year 1947 hour 5: minute 50 A. M.

21. I hereby certify that I attended the deceased from APRIL 28, 1947 to APRIL 29, 1947. that I last saw him alive on APRIL 29, and that death occurred on the date and hour stated above.

Immediate cause of death DIABETIC ACIDOSIS

Due to DIABETES MELLITUS

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations [Signature]

Of autopsy

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?

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

23. Signature [Signature] (M. D. or M.D.)

Address GENERAL HOSPITAL NO. 2 Date signed 4/29/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. Martine*.....

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.