

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X3667

21149

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUN 17 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2429

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: MENORAH HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 WEEK  
(Specify whether years, months or days)

In this community 1 MONTH  
(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. 4011 HOLLY STREET  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME LARRY RAY READE

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex MALE ( ) 5. Color or race WHITE

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

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

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

7. Birth date of deceased APRIL 10 1947  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2  
year 47 hour 12:03 minute A.M.

21. I hereby certify that I attended the deceased from May 23 1947, to June 2 1947;  
that I last saw him alive on June 1 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure

Due to Congenital Heart Disease 2 Weeks

Duration 10 days

8. AGE:

Years	Months	Days	If less than one day
	1	22	hr. min.

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

10. Usual occupation INFANT

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) 1572

Major findings: Of operations .....

Of autopsy Ante-mortem; IV Septal defect; Coarctation of aorta

PHYSICIAN .....

Underline the cause to which death should be charged statistically.

11. Industry or business .....

12. Name ROY R. READE

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

14. Maiden name GLADYS SCHANTZ

15. Birthplace CARTHAGE SOUTH DAKOTA  
(City, town, or county) (State or foreign country)

16. (a) Informant MR. ROY R. READE  
(b) Address 4011 HOLLY STREET

17. (a) BURIAL (b) Date thereof JUNE 3 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director O. N. Newcomer's Sons  
(b) Address 1401 BRUSH CREEK BLYD.

19. (a) 6-3-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? .....

(Specify type of place) (e) Means of injury .....

23. Signature Joseph Baruschine (M. D. or other) MD.  
Address Professional Bldg Date signed 6/2/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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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.....

*Bernard L. Loan*

Licensed Embalmer No.....

*4250*

P. O. Address.....

*A. C. Moore*

**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.**