

FILED NOV 4 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34713

State File No.

4452

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community 5 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 80
(c) City or town Sedalia 6
(If outside city or town limits, write "RURAL")
(d) Street No. 1516 Missouri 4
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GEORGE F TOWNSEND

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? widowed

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

7. Birth date of deceased May 24 1881
(Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days 29 If less than one day hr. min.

9. Birthplace Smith Center Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation retiree

11. Industry or business _____

MOTHER FATHER

12. Name Essae Townsend

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

14. Maiden name Julia Hart

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

16. (a) Informant Mrs. A.C. Curtis

(b) Address Sedalia Mo.

17. (a) Removal (b) Date thereof 10-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia Mo.

18. (a) Signature of funeral director Stine McClure

(b) Address 3235 Sullivan Plaza KC Mo

19. (a) 10-24-47 (b) Steraldine Walker
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23
year 1947 hour _____ minute _____ A. M.

21. I hereby certify that I attended the deceased from Oct 16
1947 to 10/23 1947
that I last saw him alive on 10/23 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia of the abdominal viscera

Due to New Spigler infection

Due to of the 1st number of the

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

Major findings: Of operations 302

Of autopsy yes

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) _____
(e) Means of injury _____

23. Signature Walter H. [unclear] (M. D. or other) M.D.
Address 830 Angyle Blvd K.C. Mo Date signed 10/24/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

NOV 18 1961
NOV 18 1961

Original Body
Removal of Organs

Return

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..... *Robert H Reed*
Licensed Embalmer No. *3745*
P. O. Address..... *N.C. 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.