

S. No. 2
M-5-43
7-5-17-39
P 1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38014

State File No. _____

FILED NOV 24 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4620

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:
KCTB HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 mos - 11 days
(Specify whether
In this community 3 YEARS
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. 2440 TRACY
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BLAND, SARA

3. (b) If veteran, WAC name war WORLD WAR II
3. (c) Social Security No. none

4. Sex F 3 Color or race NEGRO
6. (a) Single, widowed, married
divorced _____

6. (b) Name of husband or wife BLAND, CALVIN
6. (c) Age of husband or wife if
alive 45 years

7. Birth date of deceased JUNE 30 1917
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 4 1 hr. min.

9. Birthplace Miss Kogee Oklahoma
(City, town, or county) (State or foreign country)

10. Usual occupation WAC

11. Industry or business ARMY

12. Name MOORE, JOE

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

14. Maiden name AMANDA

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

16. (a) Informant KCTB HOSPITAL

(b) Address LEEDS, MISSOURI

17. (a) Burial (b) Date thereof 11/6/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leavenworth, Kansas

18. (a) Signature of funeral director Walter's Burial

(b) Address 1729 Lyndia Ave

19. (a) 11-5-47 (b) Alexandine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 31
year 1947 hour 3:15 minute A.M.

21. I hereby certify that I attended the deceased from
2-20, 1947, to 10-31, 1947
that I last saw her alive on 10-31, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY TUBERCULOSIS

Due to _____

Due to _____

Other conditions 13
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Q

Signature Wm W Hart (M. D. or other) MD

Address Gen. Hosp. #1 Date signed _____

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

MOTHER FATHER

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.....

Jerome Manlove

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.