

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29636

FILED SEP 25 1948

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3722

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:
ST. LUKE'S HOSPITAL ANNEX
(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 4 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. 3424 EAST 60TH STREET
(If rural, give location)

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

3. (a) PRINT FULL NAME MRS. MINNIE W. ADAMS

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 12
year 1948 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from 1948 to 1948
that I last saw h. alive on _____, 19____
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased NOVEMBER - 23 - 1865
(Month) (Day) (Year)

Immediate cause of death Cruphalomalous

Due to Advanced arteriosclerosis

Due to Diverticulosis jejuni

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

8. AGE: Years Months Days If less than one day

82 9 20 19 hr. _____ min.

9. Birthplace TROY CENTER PENNSYLVANIA
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business AT HOME

MOTHER FATHER { 12. Name E. SILAS WALDEN

{ 13. Birthplace NEW YORK
(City, town, or county) (State or foreign country)

{ 14. Maiden name CLARINDA SOUTHWICK

{ 15. Birthplace NEW YORK
(City, town, or county) (State or foreign country)

16. (a) Informant ROBERT D. W. ADAMS

(b) Address 5520 OAK STREET

17. (a) REMOVAL (b) Date thereof SEPT. - 13 - 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LOS ANGELES, CALIFORNIA

18. (a) Signature of funeral director G. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd

19. (a) 9-13-48 (b) Geraldine Holmes
(Date death local registrar) (Registrar's signature)

PHYSICIAN _____

Underline the cause to which death should be charged etiologically.

Major findings:
Of operations _____

Of autopsy Examined

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? _____

(Specify type of place)

While at work? _____ (b) Means of injury 0

23. Signature G. C. W. Bennett (M. D. or other) _____

Address St. Luke's Hospital Date signed 12 Sept 1948

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

Jess T. News

Licensed Embalmer No.

445-3

P. O. Address

Kansas City

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.