No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30690

Registration District No. 391 — Primary Registration District No. 1002 — Registrar's No. 3357

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:
K. C. General Hosp. #1 ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 days
(Specify whether
In this community 15 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24

(c) City or town North Kansas City 2
(If outside city or town limits, write "RURAL")

(d) Street No. 2016 Fayette Ave. 1
(If rural, give location)

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

3. (a) PRINT FULL NAME JAMES E. SHIFLETT

3. (b) If veteran, name war World War

3. (c) Social Security No. 422-01-0955

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased April (Month) 12 (Day) 1899 (Year)

8. AGE: Years 42 | Months 4 8 | Days 8 26 | If less than one day ... hr. ... min.

9. Birthplace Hawkin, Texas / (City, town, or county) ... (State or foreign country)

10. Usual occupation laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) ... (State or foreign country)

MOTHER
14. Maiden name Josie Carlile
15. Birthplace Georgia / (City, town, or county) ... (State or foreign country)

16. (a) Informant Mrs. Oline Shiflett
(b) Address North Kansas City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 9 41 (Month) (Day) (Year)
(c) Place: burial or cremation Longview, Texas

18. (a) Signature of funeral director Wailert Funeral Home
(b) Address 2332 Moniter Place; K.C.Mo.

19. (a) 9/8/41 (Date received by local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ... day 9-8-41
year ... hour ... minute 7:50 P. M.

21. I hereby certify that I attended the deceased from ... to ... 19...;
that I last saw ... alive on ... 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Brain abscess (d)	
Due to: Interstitial + subdural cerebral hemorrhage (a)	
Due to: Fracture of the skull	
Other conditions (Include pregnancy within 3 months of death): Traumatic injury to the head	

Major findings:
Of operations ...
Of autopsy yes

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) Do not know.
(b) Date of occurrence 8-15-41
(c) Where did injury occur? No K.C. Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Clay Co. Mo
(Specify type of place)
While at work (e) Means of injury Injured in fight

23. Signature Newton Public (M. D. or other)
Address K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

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..... Blaine E. Weilent

Licensed Embalmer No..... 4075

P. O. Address 2332 Monroe, Pla

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.