DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 3 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42540

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 4959

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3407 E 7th St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City, Mo. (If outside city or town limits, write "RURAL")

(d) Street No.: 3407 E 7th St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Susan Presley 624

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: John Presley

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

7. Birth date of deceased: Mar. 5, 1855 (Month) (Day) (Year)

8. AGE: Years 84 | Months 9 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace: (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Homemaker

11. Industry or business: 9

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

MOTHER
14. Maiden name: ____
15. Birthplace: (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature: Mrs. Hollie Swearingen

(b) Address: 1820 Agnes, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 2-39 (Month) (Day) (Year)

(c) Place: burial or cremation: Antioc Cemetery Nevada, Mo.

18. (a) Signature of funeral director: C.H.Blackman & Son, Inc

(b) Address: 2825 Indep. Blvd. K.C.Mo.

19. (a) Dec. 31, 1938 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 30 year: 1939 hour: 12 minute: 10 P M.

21. I hereby certify that I attended the deceased from Dec 16 - 1939 ____, 19____, to Dec 30 ____, 1939; that I last saw her alive on Dec 16 - 1939, ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Arterio sclerosis & Hypertension

Due to: None

Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Drury R. Thorn (M. D. or other)

Address: 1000 Professional Bld. Date signed

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. Druery R. Thorn
Prof Bldg. Vic 2052
1111 East 75th Terrace Ja 6936

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 H D Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. Mo

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, above space should be left blank.