

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 26 1940
Registration District No. 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1250
Registrar's No. 236

Primary Registration District No. 1002

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 Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days
(Specify whether
In this community 30 YEARS
years, months or days)

3. (a) PRINT FULL NAME Alice Woolington
3. (b) If veteran, name war No
3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife JOHN WOOLINGTON
6. (c) Age of husband or wife if alive UNK. years
7. Birth date of deceased 8 26 1874
(Month) (Day) (Year)

8. AGE: Years 65 Months 4 Days 19
If less than one day hr. min.

9. Birthplace SHARPSVILLE IND.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER
12. Name WOODSON PURVIS
13. Birthplace IND.
(City, town, or county) (State or foreign country)
14. Maiden name AMANDA PURVIS PURVIS
15. Birthplace IND.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature MRS. MINTA CONKLIN

(b) Address 1334 JEFFERSON, K.C.M.

17. (a) BURIAL (b) Date thereof 1-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LOUIS BERG, KANSAS

18. (a) Signature of funeral director SHAW FUNERAL HOME

(b) Address 6606 INDEPENDENCE, AVE.

19. (a) Jan 17 1940 (b) M. M. Grove
(Date received local Registrar) (Registrar's signature)

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. 1334 Jefferson
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15th
year 1940 hour 9 minute 50 A.M. M.

21. I hereby certify that I attended the deceased from 12-26-39, 19____, to 1-15-40, 19____;
that I last saw her alive on 1-15-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus
Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy None
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 1

23. Signature Dr. De Maria M.D. Date signed 1-16-40
Address Supt. U. C. Gen. Hospital (M. D. or other)

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.....

JOE B Yoder....., Registered Apprentice No. # 233
working under my personal supervision.

Signed

J. P. Sheil

Licensed Embalmer No. 3625

P. O. Address K.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, above space should be left blank.