

Registration District No. 395

Primary Registration District No. 551A

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson **FILED FEB 12 1940**  
(b) City or town Blue Springs R.F.D.  
(c) Name of hospital or institution St. A. Bar's Township  
3 miles west Blue Springs  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community 40 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Blue Springs Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3 miles west Blue Springs  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18  
year 1940 hour 11 minute 45 P.M.  
21. I hereby certify that I attended the deceased from February 23, 1938, to Jan. 18, 1940,  
that I last saw her alive on Jan. 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 1 hour  
Due to arteriosclerosis 3 years

Due to \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Clint L. Miller (M. D. or other) \_\_\_\_\_  
Address Lee Summit, Mo. Date signed 1-18-40

3. (a) PRINT FULL NAME Ida M Baxter 236  
3. (b) If veteran, name war XX 3. (c) Social Security No. XX

4. Sex F M 5. Color White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joessiah 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Sept 28 1870  
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jackson Co. MO  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business XX 0

12. Name Almae Owens I  
13. Birthplace Ills I  
(City, town, or county) (State or foreign country)

14. Maiden name Barnhouse  
15. Birthplace Ills  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Anna Murphy  
(b) Address Blue Springs Mo

17. (a) Burial (b) Date thereof Jan 21 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Cem  
18. (a) Signature of funeral director R B Webb  
(b) Address Blue Springs Mo 357

19. (a) Feb 5, 1940 (b) F W Tuttle MO  
(Date received local registrar) (Registrar's signature)

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.

OCT 16 1942

SEP 9 1946

**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. 234-3  
working under my personal supervision.

Signed RB Webb

Licensed Embalmer No. 235-3

P. O. Address Blue Springs

**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.**