

WHILE FILLING OUT THIS FORM USE CHARCOAL BLACK INK—MAKE A PERMANENT RECORD

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.

FILED MAR 11 1940
599

Registration District No. _____

Primary Registration District No. 1002

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:
2905 Harrison Ave.
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution 10 Yrs. (Specify whether
In this community 4-8-0
years, months or days)

3. (a) PRINT FULL NAME Mrs. Maude SCULLY.

3. (b) If veteran, name war No 3. (c) Social Security No. NO

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife James P. Scully 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased July 4th 1886
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>53</u>	<u>7</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Frank Dowell.

13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Marcella Harlow.

15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Mary Dowell.
(b) Address 2905 Harrison (Sister)

17. (a) Removal (b) Date thereof 2/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bucklin Missouri.

18. (a) Signature of funeral director Melody-McGilley.
(b) Address K. C. Mo.

19. (a) Feb. 6, 1940 (Date received local registrar) M. M. Croese (Registrar's signature)

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. 2905 Harrison Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6th
year 1940 hour 6 P. M. minute 30 P. M.

21. I hereby certify that I attended the deceased from Aug 10th
1939 to Feb. 6, 1940

that I last saw her alive on Feb 6th 1940, 1940
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 Metastasis-Malnutrition
(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 Frances Henry (M. D. _____)
Address 2910 Harrison St. Date signed _____

Kansas City, Mo.

Dr. Frances Henry.
2910 Harrison.

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.....

Licensed Embalmer No.

P. O. Address.....

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.