

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9590

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1024

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. Gen. Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
40 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARGRET STANLEY 354

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

4. Sex Femal 5. Color or race W 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased June 24 1869  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 8 9 hr. min.

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

10. Usual occupation

11. Industry or business House Wife

MOTHER FATHER { 12. Name norecord 9  
13. Birthplace " (City, town, or county) (State or foreign country)

{ 14. Maiden name No record 9  
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Stanley

(b) Address 4409 East 10 St

17. (a) Burial (b) Date thereof Mar 6 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn Kansas City

19. (a) Mar 8, 1940 (b) M. M. Browne  
(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. 4409 East 10th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd  
year 1940 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from 2-29-40, 19\_\_\_\_, to 3-3-40, 19\_\_\_\_; that I last saw her alive on 3-3-40, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Auricular fibrillation Cardiac decompensation

Due to 9502

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 \_\_\_\_\_

23. Signature R. J. De Manno M.D. (M. D. or other)  
Supt. K. C. Gen. Hospital, K. C. Mo. Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING 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.

REV. 5-17-39 1 X10811

**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 me  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Denzil C. Browning  
Licensed Embalmer No. 2724  
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.**