DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9595

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 1029

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: 5631 Highland (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 Most of life

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. 5631 Highland (If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Mary Ella Comer 560

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frank Comer

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

7. Birth date of deceased March (Month) 15 (Day) 1861 (Year)

8. AGE: Years 78 Months 11 Days 20 If less than one day ____ hr. ____ min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name George Comer
13. Birthplace Louisville (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name Sarah Dyer
15. Birthplace ____ (City, town, or county) Virginia (State or foreign country)

16. (a) Informant's own signature Mrs. Elsie Smith

(b) Address 5631 Highland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 7-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) Mch 6, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 5th year 1940 hour 3:00 minute A M.

21. I hereby certify that I attended the deceased from 8-18-37, 19__, to Mar 5, 1940 that I last saw her alive on Mar 4, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypertension	8 yrs
Myocarditis &	
Mitral insufficiency	6 yrs.
Due to Cerebral arterio	
sclerosis 92a	1 yr.
Due to	
Other conditions Chronic Cystitis (Include pregnancy within 3 months of death)	4 yrs.

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury

23. Signature E. Petry (M. D. or other) M.D.

Address 306 Argyle Bldg Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. 8-17-39 F X19511

Dr. E. L. Petry

Argyle

Ha 5997

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 Cecil R Matthes

Licensed Embalmer No. 3807

P. O. Address Fe 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.