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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1478

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 11 days
(Specify whether
In this community 29
years, months or days)

8. (a) PRINT FULL NAME IDA MAY ARBUCKLE 612
8. (b) If veteran, name war. No 8. (c) Social Security No. None

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

6. (b) Name of husband or wife David C. Arbuckle 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 5 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 28 If less than one day
hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business ?

12. Name No Record

13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Russell W. Arbuckle

(b) Address 5027 South Benton

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

(c) Place: burial or cremation Mt Washington

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

(b) Address 918 Brooklyn Kansas City Mo.

19. (a) April 5, 1940 (b) M. M. Crowe
(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. 415 E. 13th St. Terrace
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd
year 1940 hour 7 minute 25 A. M.

21. I hereby certify that I attended the deceased from
3-23-40, 19____, to 4-3-40, 19____;
that I last saw h. er alive on 4-3-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute pulmonary edema Duration _____

Due to Chronic myocarditis

Due to _____
Other conditions Terminal acute ~~myocarditis~~ ~~enteritis~~
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: _____
Of operations _____
Of autopsy See above

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 1

28. Signature P. J. DeManna M.D. (M. D. or other)
Address Supt. K. C. Gen. Hospital, K. C. Mo. 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. 9-17-39
FORM 1 X19311

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 C. H. Wise
#2570
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.