

MAY 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14061**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1773**

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(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 5 days
In this community 13 Yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Magdalena Montoya **5311**
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clemente Montoya 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased July 22 1899
(Month) (Day) (Year)

8. AGE: Years 40 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Leonida Ramos
13. Birthplace Mexico (City, town, or county) (State or foreign country)
14. Maiden name Francisco Solorio
15. Birthplace Mexico (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clemente Montoya
(b) Address 2324 Monitor place

17. (a) Burial (b) Date thereof 4 27 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Weillert Funeral Home
(b) Address 2332 Monitor Place, K. C. Mo
19. (a) April 26, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2324 Monitor Place
(If rural, give location)
(e) If foreign born, how long in U. S. A. 26 Yrs. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 24th
year 1940 hour 3 minute 08 P. M.

21. I hereby certify that I attended the deceased from April 19th, 1940, to April 24th, 1940; that I last saw her alive on April 24th, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Terminal bronchopneumonia cerebral edema and congestion Duration

Due to Diabetes mellitus with acidosis

Due to _____
Other conditions 54
(Include pregnancy within 8 months of death)

PHYSICIAN
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?

While at work? _____ (Specify type of place) (e) Means of injury !
23. Signature P. J. De Maria M.D. (M. D. or other)
Address Supt. K.C. General Hospital, K.C. Mo Date signed _____

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.

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 Blaine E. Weiland

Licensed Embalmer No. 4675

P. O. Address 2332 Monitor Pl

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.