S. No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 17 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17458

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1985

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life (Specify whether
In this community years, months or days)

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. 3138 Karnes
(If rural, give location)

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

3. (a) PRINT FULL NAME Winifred Kennedy Graham 650

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Fe

5. Color or race Wh

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

6. (b) Name of husband or wife Leonard A. Graham

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Nov. 19, 1910 (Month) (Day) (Year)

8. AGE: Years 29 Months 5 Days 22 If less than one day hr. min.

9. Birthplace Caplinger Mills Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Kennedy
13. Birthplace Caplinger Mills, Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Saloma Garver
15. Birthplace Burton County Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Leonard A. Graham
(b) Address 3138 Karnes

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-40 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave.

19. (a) May 13, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 1940 hour 12 35 P.M. minute M.

21. I hereby certify that I attended the deceased from February, 1940, to May 11, 1940; that I last saw her alive on May 11, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Embolic	
Due to Pelvic inflammation	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Pelvic Inflammation	
Of autopsy Yes	

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 [illegible] (M. D. or other)
Address 140 [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

1111B

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 Thomas E. Quirk

Licensed Embalmer No. 3775

P. O. Address 436 Forest

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
°I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17458

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 1985

SUPPLEMENTARY

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: ..... (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 .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town ..... (If outside city or town limits write "RURAL")

(d) Street No. 3138 Karnes (If rural, give location)

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

3. (a) PRINT FULL NAME Winifred K. Graham

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race .....

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

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

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

7. Birth date of deceased ..... (Month) (Day) (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

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

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

16. (a) Informant .....
(b) Address .....

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

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 5/13/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 1940 hour ..... minute ..... M.

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

Immediate cause of death Pulmonary Embolism

Due to Pelvic Inflammation non Puerperal

Due to .....

111a

Other conditions ..... (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

Duration

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 ..... (M. D. or other) .....
Address ..... Date signed .....

S-17458