S. No. 2
—11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17518

JUN 17 1940

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2045

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. Luke's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether In this community 12 Years years, months or days)

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. 1508 East 42nd Street (If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Doris Martin De Wing

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Mr. Kenneth D. De Wing

6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased August (Month) 20 (Day) 1909 (Year)

8. AGE: Years 30 Months 87 Days 27 If less than one day ___ hr. ___ min.

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

10. Usual occupation Housewife

11. Industry or business ------

FATHER
12. Name Fred J. Martin
13. Birthplace (City, town, or county) West Virginia (State or foreign country)

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

16. (a) Informant Kenneth De Wing

(b) Address 1508 E 42nd

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) May 17, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16th year 1940 hour 9 minute 25 P. M.

21. I hereby certify that I attended the deceased from Oct 26, 1939, to May 16, 1940 that I last saw her alive on May 16, 1940, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Pulmonary Edema	8 hrs.
Due to Anemia of Pregnancy (without hemorrhage)	days
Due to Toxemia of Pregnancy	3 mos.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Pronounced Anemia (Hg 25%)

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 Ralph R. Wilson (M. D. or other) M.D.

Address 201 Plaza St. Bldg. Date signed 5/17/40

R. C. Wilson

(Licensed Embalmer's Statement on Reverse Side)

147

201. Plaza Theatre Bldg.
2-4

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 C. Henry Quisenberry

Licensed Embalmer No. 4070

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.

S. No. 2B
M—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. 17518

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2045

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C.
(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
In this community ..... years, months or days)

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

3. (a) PRINT FULL NAME Doris M. De Wing

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

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

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 20 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) May 17/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 16 day 40
year ..... 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 Acute Pul. edema 147

Due to Anemia of pregnancy without hemorrhage -

Due to Toxemia of pregnancy 3 mo

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

Major findings: Of operation Stillborn Child Del. May 16, 1940

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

S-17518