S. No. 2
—11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24225

AUG 14 1940

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2835

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 6 days (Specify whether

In this community 30 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. 533 Gladstone (If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Alice W. LASWELL 240

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Thomas H. Laswell

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased November 4th, 1902. (Month) (Day) (Year)

8. AGE: Years 37 Months 8 Days 7 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Frank P. Clark
13. Birthplace Washington (City, town, or county) D. C. (State or foreign country)

MOTHER
14. Maiden name Pauline S. Foss
15. Birthplace Buffalo (City, town, or county) New York (State or foreign country)

16. (a) Informant Frank P. Clark

(b) Address 637 East 7 4 th St., KC, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/40. (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director Mellody-McGilley

(b) Address K. C. Mo.

19. (a) July 15, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11 year 1940 hour 8.30 minute P M.

21. I hereby certify that I attended the deceased from July 3, 1940, to July 11, 1940, that I last saw her alive on July 11, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis & Illeus — Duration 7/8/40.

Due to 54 B

Due to

Other conditions Fibroid Uterus (Include pregnancy within 3 months of death)

Major findings: Of operations Fibroid uterus

Of autopsy General Peritonitis & Illeus

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 612 Professional Bldg Date signed 7/11/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 2999.

P. O. Address K.C. Mo.

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

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