V. S. No. 2
M—11-10-39
ev. 5-17-39
I X21492

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

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24272
2882

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

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. & 7 days (Specify whether years, months or days)
In this community: No Record

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.: 1228 Park
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: MAUDE TARR 600

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: Joe V. Tarr

6. (c) Age of husband or wife if alive: 58 years

7. Birth date of deceased: Illinois (Month) no record (Day) (Year)

8. AGE: Years 49 | Months - | Days - | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: ---------

MOTHER FATHER

12. Name: John Miller

13. Birthplace: Illinois (City, town, or county) ____ (State or foreign country)

MOTHER

14. Maiden name: No Record

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

16. (a) Informant: Mr. Joe V. Tarr, 1228 Park, City
(b) Address: 1228 Park

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 19th, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park, K.C.Mo.

18. (a) Signature of funeral director: Mrs.C.L.Forster
(b) Address: 918 Brooklyn Avenue, K.C.Mo.

19. (a) July 18, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th year 1940 hour 10 minute 15 A. M.

21. I hereby certify that I attended the deceased from June 10th 40, 19__, to July 17th 1940, 19__; that I last saw h er alive on July 17th, 1940, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of mouth with metastases — Duration: 45

Due to: ____

Due to: ____

Other conditions: Generalized toxemia and cachexia.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ____
Of autopsy: See above

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: Doney R. Thorn (M. D. or other)
Address: Med. Dir. K. C. Gen. Hospital, K.C.Mo. Date signed: ____

(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 me

..... Registered Apprentice No. .....

working under my personal supervision.

Signed E H Nise

Licensed Embalmer No. 2570

P. O. Address Kam

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.