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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 23 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25390

Registration District No. 404 Primary Registration District No. 5-58 Registrar's No. 77

1. PLACE OF DEATH:

(a) County Jackson Wash Twp

(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: 8444 Wornall Road (If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution 2 months (Specify whether In this community 32years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 5823 Holmes (If rural, give location)

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

3. (a) PRINT FULL NAME Amanda Caroline Munford 516

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Thomas James Munford

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

7. Birth date of deceased July (Month) 25, (Day) 1865 (Year)

8. AGE: Years 74 Months 11 Days 14 If less than one day ___ hr. ___ min.

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

10. Usual occupation Home Maker

11. Industry or business At Home

FATHER
12. Name William C. Baskett,
13. Birthplace ___ (City, town, or county) Va (State or foreign country)

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

16. (a) Informant Clifton W. Munford

(b) Address 5823 Holmes, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11-40 (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cem Kearney, Mo.

18. (a) Signature of funeral director C.H.Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd. K.C.Mo.

19. (a) 8-9-40 (Date received local registrar) (b) Mrs Jos T Brennan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th year 1940 hour 2 minute P M.

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

Deputy Coroner

Immediate cause of death

Duration

Acute pulmonary edema

Due to Brown atrophy of the heart

Carcinoma of right breast

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 50

Of autopsy

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? ___ (c) Means of injury

23. Signature [signature] (M. D. or other) 5

Address 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.....

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

working under my personal supervision.

Signed F. D. Blackman

Licensed Embalmer No. 3639

P. O. Address R.C.M.

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

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