

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. **399**

Primary Registration District No. **1002**

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: N.E. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether
In this community 20 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Melinda C. Delahay Dwyok

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Alois Dwyok 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased June 10, 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 4 If less than one day hr. min.

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

10. Usual occupation Homemaker

11. Industry or business At Home

MOTHER FATHER { 12. Name Unknown 9

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Paul A. Sevart

(b) Address 4200 Norledge, K.C. Mo.

17. (a) Burial (b) Date thereof Aug. 16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery K.C. Mo.

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

(b) Address City

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

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 3118 Gardner
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14th
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from April 1937
1937, to Aug 14, 1940
that I last saw him alive on Aug 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Volume Duration
insufficiency

Due to Chronic endocarditis

Due to Rheumatic Arthritis

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

Major findings: Of operations none 92 W

Of autopsy none

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? 361

While at work? _____ (Specify type of place)
(e) Means of injury 5

23. Signature Earl Van Jones (M. D. or other) 10

Address 100 1/2 S. Baber Date signed 8-15-40

Dr. Earl V. Jones 11 100 S. Askew

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 W. D. Blackman
Licensed Embalmer No. 3639
P. O. Address 111 E. 7th St. 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27590

Registration District No.

Primary Registration District No.

Registrar's No. 3224

1. PLACE OF DEATH:

(a) County Jackson R.C.
(b) City or town Jackson R.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)

3. (a) PRINT FULL NAME Melinda C.D. Dwyck
(b) If veteran, name war
(c) Social Security No.

4. Sex F 5. Color or race W
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive year

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.....

MOTHER FATHER { 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

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

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

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

19. (a) (b)
(Date received local registrar) (Registrar's signature)

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.

19. DATE OF DEATH. Month Aug day 14 - 4 P
year hour minute M.

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

Immediate cause of death Cardiac
vascular insuff.
Chr. Embolic stroke
Rheumatic Arthritis

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

Major findings:
Of operations..... g2w
Of autopsy.....

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?

While at work? (Specify type of place)
(e) Means of injury.....

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

