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

FILED SEP 5 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27757

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 3391

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: General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-2-40-8-22-40 (Specify whether years, months or days)

In this community: 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson

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

(d) Street No.: 1322 Woodland, 1st fl.
(If rural, give location)

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

3. (a) PRINT FULL NAME: Mary Taylor 460

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: Negro

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

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: X Unknown (Month) (Day) (Year)

8. AGE: Years X 63 | Months -- | Days -- | If less than one day ____ hr. ____ min.

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

10. Usual occupation: none

11. Industry or business: X None

MOTHER FATHER

12. Name: X unknown 9

13. Birthplace: X unknown (City, town, or county) 9 (State or foreign country)

14. Maiden name: X unknown

15. Birthplace: X unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Record Clerk

(b) Address: General Hospital #2

17. (a) X Burial (Burial, cremation, or removal) (b) Date thereof: X Aug. 29, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Blue Ridge

18. (a) Signature of funeral director: Ideal Plum

(b) Address: 4469 E 12th St

19. (a) Aug. 28, 1940 (Date received local registrar) (b) M. McCrowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 22 year 40 hour 5 minute 05 A. M.

21. I hereby certify that I attended the deceased from 8-2- 1940, to 8-22- 1940, that I last saw her alive on 8-22- 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	
Due to: Hypertensive Type of Heart Disease	
Due to: Chronic Nephritis	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — 131

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: Gen. Hosp. #2 Date signed: 8-22-40

(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. 3388

P. O. Address K.C. Mo

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.