

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:  
1715 Montgall **2**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution none  
 (Specify whether  
 In this community 52 yrs.  
 years, months or days)

3. (a) PRINT FULL NAME Mary Jane Wood **301**3. (b) If veteran, name war No 3. (c) Social Security No. No4. Sex Fem 5. Color or race White 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Elisha Hamilton Wood 6. (c) Age of husband or wife if alive 60 years7. Birth date of deceased 3 3 1884  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
56 5 26 hr. min.9. Birthplace Lee's Summit Mo  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife11. Industry or business xx

MOTHER FATHER  
 { 12. Name William Henry Cubine  
 { 13. Birthplace Virginia  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name Martha Warran  
 { 15. Birthplace Virginia  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elisha Wood(b) Address 1715 Montgall17. (a) Burial (b) Date thereof 8/31/40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt. Moriah18. (a) Signature of funeral director John P. Sheil(b) Address 6606 Indep. Ave., K. C. Mo19. (a) Aug. 30, 1940 (b) M. M. Craive  
(Date received, local registrar) (Registrar's signature)

## 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. 1715 Montgall  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? No years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29th  
year 1940 hour 7:30 minute am21. I hereby certify that I attended the deceased from Aug 2nd  
1940 to Aug 29 1940  
that I last saw her alive on Aug 27 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral HemorrhageDue to arterial HypertensionDue to Paralyzed Waist DownOther conditions Paralyzed Waist Down  
(Include pregnancy within 3 months of death)

PHYSICIAN B. A.  
 Underline the cause to which death should be charged statistically.  
 Major findings:  
 Of operations no  
 Of autopsy no

## 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?  
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While at work? (Specify type of place) (e) Means of injury 323. Signature A. M. Adams (M. D. or other) D. O.  
Address 423 Lee Bldg Date Aug 30, 1940

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**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.....

P. O. Address.....

**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.**