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13-40
7-39
X29159

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:
5018 Bellefontaine Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community 17 years
years, months or days)

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. 5018 Bellefontaine Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 4 day 4th
year 1940 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from
1938 to Sept 4, 1940
that I last saw her alive on Sept 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death:
Cardiac Failure Duration 2 days

Due to Hypertension
Arterio sclerosis spere

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy no
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?

While at work? (Specify type of place) (e) Means of injury 1
23. Signature [Signature] (M. D. or other)
Address 315 Alameda Road Date signed 9-4-40

3. (a) PRINT FULL NAME Mrs. Mary Frances Moore

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

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

6. (b) Name of husband or wife Mr. George J. Moore 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased February 6 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 6 26 hr. min.

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

10. Usual occupation At Home

11. Industry or business ---

12. Name George C. Henderson

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

14. Maiden name Martha A. Boles

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

16. (a) Informant [Signature]
(b) Address 5018 Bellefontaine Ave.

17. (a) Burial (b) Date thereof Sept. 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address 1401 Brush Creek Blvd.

19. (a) Sept. 6, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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

67

2nd floor - Wagon
2. 5:30

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 *A. A. Newcomer*

Licensed Embalmer No. 40413

P. O. Address R. C. 9th

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 00000

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3494

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5018 Bellefontaine
(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 Mary Frances Moore

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female race White 5. Color or race White 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

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 9/6/40 (b) M. M. Grove
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept. day 4th
year 1940 hour..... minute..... M.

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

Immediate cause of death Cardiac Failure
Cardiac Decomposition

Due to Hypertension
Arterio-sclerosis 5 Mrs.
Due to Arterio-sclerotic Heart Disease

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

Major findings:
Of operations..... 95 B 2

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)
Address..... Date signed.....

Duration a days 7

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

598
824

5-30931

40

7 1/2

47 1/2