No. 2
11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37582

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4180

FILED DEC 11 1940

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: K.C. General Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 7-15-40 (Specify whether) to present time has been under care of Gen. In this community Hosp. physicians (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. 3231 Prospect Avenue (If rural, give location)

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

3. (a) PRINT FULL NAME Mrs MARY BOLT

3. (b) If veteran, name war No

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Ervin Bolt

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

7. Birth date of deceased June (Month) 29 (Day) 1864 (Year)

8. AGE: Years 76 Months 4 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace No Record (City, town, or county) 9 (State or foreign country)

10. Usual occupation Home 9

11. Industry or business 9

FATHER
12. Name No Record
13. Birthplace No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. C. Wirt
(b) Address 242 East 73rd Terrace

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director J. W. Wagner
(b) Address K. C. Mo

19. (a) 11-2-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1st year 1940 hour 11 minute 15 A.M. M.

21. I hereby certify that I attended the deceased from July 15th, 1940, to Nov. 1st, 1940; that I last saw her alive on 10-24-40, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death SENILE DEMENTIA

Due to 7/12

Due to

Other conditions Pernicious Anemia and Malnutrition (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

Duration

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? (e) Means of injury

23. Signature Dwelly R. Shore (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital 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 A. R. Hauschild

Licensed Embalmer No. 4159

P. O. Address K. C. 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.