

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 220

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:  
4270 - main St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community 46 years, months or days

3. (a) PRINT FULL NAME Jessie May Raymond  
8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex Fe 5. Color or race Wh. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ernest Raymond 6. (c) Age of husband or wife if alive 88 years

7. Birth date of deceased: May 7 1894  
(Month) (Day) (Year)

8. AGE: Years 46 Months 8 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House - Wife

11. Industry or business \_\_\_\_\_

12. Name Charles Cook

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

14. Maiden name Lena Chalk

15. Birthplace no record  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ernest Raymond

(b) Address 4270 main

17. (a) Burial (b) Date thereof 1-15-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hill

18. (a) Signature of funeral director Bergman turned down  
(b) Address 4306 - main street

19. (a) Jan 15 1941 (b) Dr. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 5  
(d) Street No. 4270 main 1  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13  
year 1941 hour 3:45 minute 2 M.

21. I hereby certify that I attended the deceased from Jan 4/41  
Jan 4, 1941, to Jan 12, 1941;  
that I last saw her alive on Jan 12, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral pneumonia Duration 5 days

Due to paralysis of intestines & urinary bladder

Due to hypostatic pneumonia

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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? \_\_\_\_\_

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

28. Signature M. G. A. Berner (M. D. or other) DO

Address 27418 charlato Date signed 1/14/41

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

130

Do the work.  
2748 - Charlott.  
In 2993

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 Hany Bergma

Licensed Embalmer No 2041

P. O. Address Kan. City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

**MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 220

**1. PLACE OF DEATH:**

(a) County Jackson K.C.  
(b) City or town K.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 Jennie M. Raymond

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced M

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)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 1/15/41 (b) M. M. Crowe  
(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 Jan. day 13 - 1941  
year..... 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 Uremic poison Duration

Due to Paralysis intestines

urinary bladder

Due to Cerebral hemorrhage

hyperstatic pneumonia

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

Major findings: Of operations..... 830

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 F. A. D. Smith (M. D. or other) M.D.

Address 7748 Charlotte Date signed 3/7/41

**SUPPLEMENTAL**

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

S-1260