

S. No. 2  
4-1-4-41  
7. 5-17-39  
VI X26390

DEPARTMENT OF COMMERCE  
MISSOURI STATE BOARD OF HEALTH  
**APR 13 1941**  
Registration District No. 399

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

State File No. 9521  
Registrar's No. 930

Primary Registration District No. 1002

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

**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 25 days  
(Specify whether  
In this community 30 yrs  
years, months or days)

**3. (a) PRINT FULL NAME** LAURETTA AUDSLEY  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex Female 5. Color or race wh  
6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Wm. D.  
6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased Sept 14, 1868  
(Month) (Day) (Year)

**8. AGE:** Years 72 Months 5 Days 21  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business At home

12. Name Olma G. Quinn

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

14. Maiden name Martha Hoffman

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

16. (a) Informant Wm. D. Audsley

(b) Address 905 Paseo

17. (a) Burial (b) Date thereof 3-7-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Admission Mo

18. (a) Signature of funeral director W. H. Blackman

(b) Address K.C. Mo  
19. (a) 3/6/41 (b) M. D. Browne  
(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. 905 Paseo  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 5th  
year 1941 hour 3 minute 20 P. M.  
21. I hereby certify that I attended the deceased from 2-8-41 19 to 3-5-41 19  
that I last saw h. er alive on 3-5-41 19  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
Duration

Due to Abdominal ascites; Cirrhosis of Liver; Obstructive jaundice

Due to 12-1-41  
Other conditions: Gastric ulcer  
(Include pregnancy within 3 months of death) 12412

Major findings: See above  
Of operations  
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?

23. Signature Dr. K. C. Gen. Hospital (M. D. or other)  
Address Med. Dir. K.C. Gen. Hospital Date signed

**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..... *H. D. Blackman* .....

Licensed Embalmer No. *3639* .....

P. O. Address..... *R. C. M* .....

**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.**