

No. 2  
-1-4-41  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20717

State File No.

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 2217

048

FILED JUL 31 1941

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:  
1121 East 12th St. 1  
(If not in a hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community Life (Specify whether 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. 4215 Highland  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 Day 10 Year 1941  
hour 1:15 minute P.M.

21. I hereby certify that I attended the deceased from 19 1941  
that I last saw Corson alive on 19 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Coronary Occlusion  
Coronary Atherosclerosis

Other conditions (Include pregnancy within 3 months of death)  
94

Major findings:  
Of operations  
Of autopsy

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) (e) Means of injury  
While at work  
23. Signature Dr. Russell Jensen (M. D. or other)  
Address Kennett Date signed

3. (a) PRINT FULL NAME William B. Feminore

3. (b) If veteran, name war L 3. (c) Social Security No. 487-09-9499

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Jane Feminore 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased Jan 11 1890 (Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 29 If less than one day hr. min.

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

10. Usual occupation Shipping Clerk

11. Industry or business West. Ind.

12. Name Henry W. Feminore

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

14. Maiden name Unknown

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

16. (a) Informant Jane Feminore

(b) Address 4215 Highland

17. (a) Burial (b) Date thereof 6/13/41 (Month) (Day) (Year)

(c) Place: burial or cremation Graves City Mo

18. (a) Signature of funeral director Snow Mackey

(b) Address 2315 Kennwood Blvd

19. (a) 6/12/1941 (Date received local registrar) (b) M. H. Crowe (Registrar's signature)

**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 \_\_\_\_\_

*Ray E. Snow*

Licensed Embalmer No. *2560*

P. O. Address. *1807 East 29*

**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.**