No. 2
1-4-41
17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30591

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3348

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kans City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 315 So Jackson (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Mary Agnes Cohlmeyer

3. (b) If veteran, name war Mo

3. (c) Social Security No. —

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife John C Cohlmeyer

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

7. Birth date of deceased Oct 26 (Month) 1880 (Day) (Year)

8. AGE: Years 60 Months 12 Days 12 If less than one day ..... hr. ..... min.

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

10. Usual occupation at home

11. Industry or business .....

FATHER
12. Name Unk Hughes
13. Birthplace ..... (City, town, or county) O Mo (State or foreign country)

MOTHER
14. Maiden name Emma Becker
15. Birthplace ..... (City, town, or county) O Mo (State or foreign country)

16. (a) Informant Mrs. L. H. Becker

(b) Address 5700 Tracy

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington

18. (a) Signature of funeral director Mrs. C. L. Foster

(b) Address 918 Brooklyn

19. (a) 9/8/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8 year 1941 hour 3 minute 45 a M.

21. I hereby certify that I attended the deceased from April 1939 to 9/8/41 19..; that I last saw her alive on 9/7/41 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: cachexia carcinomatosis

Due to carcinoma of ovaries

Due to 49a

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Exploratory April 1939 carcinomatosis

Of autopsy carcinoma of ovaries

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 O

23. Signature R R Loffey (M. D. ~~or other~~)

Address 1103 Grand Date signed 9/8/41

(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 Dwight C. Bivining

Licensed Embalmer No. 2764

P. O. Address Kansas City, Mo

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

If this body is not embalmed, fact should be so stated above.