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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34107

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 4047

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: Lakeside Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community 7 years 0

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 048 3 8

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

(d) Street No. 1315 E 31st.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Mrs Helen Porter

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Fe 1

5. Color or race: White

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

6. (b) Name of husband or wife: Leslie O.

6. (c) Age of husband or wife if alive: 39 years

7. Birth date of deceased: June (Month) 21 (Day) 1914 (Year)

8. AGE: Years 27 | Months 4 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace: Fortuna (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Grover C Scott
13. Birthplace: (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name: Edith Woods
15. Birthplace: (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant: Mrs Edith Scott
(b) Address: 609 E 9th

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-2-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Tipton Mo

18. (a) Signature of funeral director: Pedo Bros Funeral Home
(b) Address: 1416 Main Ave.

19. (a) 10/30/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30 year 1941 hour 8:35 minute P. M.

21. I hereby certify that I attended the deceased from October 22, 1941, to October 30, 1941 that I last saw her alive on October 30, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure
Bilateral lobar pneumonia

Due to:

Due to:

Other conditions: Acute app
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Acute appendicitis
Cystic Rt. ovary, Bilateral salpingitis
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)
While at work? (e) Means of injury

23. Signature: Chas. A. Schwab M.D. (M.D. or other)
Address: 1102 E 47th Date signed 10-30-41

(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 Orville H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Kano, City Kano

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.