

No. 2  
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37448

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

DEC 22 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4243

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

1. PLACE OF DEATH:

(a) County. Jackson

(b) City or town. Kansas City

(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. 1 Mo. & 16 days  
(Specify whether In this community. Unknown years, months or days)

3. (a) PRINT FULL NAME. Catherine Budd

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

3. (c) Social Security No. No

4. Sex. Female

5. Color or race. White

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

6. (b) Name of husband or wife. \_\_\_\_\_

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

7. Birth date of deceased: February 29, 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>8</u>	<u>13</u>	hr. min.

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

10. Usual occupation. None

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

MOTHER FATHER { 12. Name. William Budd

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

14. Maiden name. Elizabeth Cage

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

16. (a) Informant. Little Sister of Poor

(b) Address. Kansas City, Mo.

17. (a) Burial (b) Date thereof. Nov. 14, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. St. Mary's Cem. Quirk & Tobin

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

(b) Address. Kansas City, Mo.

19. (a) 11-15-41 (b) M. M. Crowe  
(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. Little Sisters of the Poor  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12th  
year 1941 hour 4:00 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 9-27-41 to 11-12-41, 19\_\_\_\_  
that I last saw her alive on 11-12-41, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death. Hypostatic pneumonia and senility  
Fracture of femur, accidental fall

Due to. \_\_\_\_\_

Due to. \_\_\_\_\_

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

Major findings: \_\_\_\_\_

Of operations. \_\_\_\_\_

Of autopsy. None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 123

(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. 5

23. Signature. Mary R. Shon (M. D. or other) \_\_\_\_\_

Address. Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

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Duration

PHYSICIAN

Underline the cause to which death should be charged statistically!

STATE OF CALIFORNIA  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF FUNERAL SERVICE

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. **4243**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**K.O. General Hospital No. 1**  
(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)

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) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Catherine Budd**

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

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**81 8 13** min.

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

10. Usual occupation.....

11. Industry or business.....

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) **11/15/41** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **12th**  
year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Hyostatic pneumonia and senility**  
**Fracture of femur, accidental fall**

Due to.....

Due to.....

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

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) **Accident**

(b) Date of occurrence **not recorded**

(c) Where did injury occur? **Kansas City Jackson Mo**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Little Sisters of the Poor (Home)**

While at work? **no** (Specify type of place) (e) Means of injury **Fall**

23. Signature **Drury R. Thom** (M. D. or other)

Address..... Date signed.....

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

MOTHER, FATHER

SUPPLEMENTAL

S-37448

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**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.....

Licensed Embalmer No.....

P. O. Address.....

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