

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1150  
Registrar's No. 347

FILED FEB 11 1942  
Registration District No. 3929

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:  
315 West 9th. Street /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Yrs (Specify whether years, months or days)

In this community 8 Yrs (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. 315 West 9 St.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Willard J. Daugherty

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Lela J. Daugherty

6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased Oct 12 1901  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>3</u>	<u>12</u>	hr. min.

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

10. Usual occupation Railroad Mechanic

11. Industry or business

12. Name James Burrell Daugherty

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

14. Maiden name No Record

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

16. (a) Informant Lela J. Daugherty

(b) Address 315 West 9 St.

17. (a) Removal (b) Date thereof Jan 27-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eldon Mo

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

(b) Address 918 Brooklyn

19. (a) 1-26-42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-24-42 year hour minute 4:50 M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw Robert Crowe and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to

Due to 108

Other conditions (Include pregnancy within 9 months of death)

Major findings: Of operations

Of autopsy

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 W. M. Crowe (M. D. or other)  
Address ICM Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Denzil C. Browning  
Licensed Embalmer No. 2764  
P. O. Address 7-c mo

**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.**