

V. S. No. 2
 50M-5-42
 v. 5-17-39
 I X32873

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **20270**

FILED JUL 17 1942
 Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **2586**

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:
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 **10 days**
(Specify whether years, months or days)
 In this community **11 yrs.**

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. **1925 Monroe**
(If rural, give location)
 (e) Citizen of foreign country? **No**
 If yes, name country

3. (a) PRINT FULL NAME **Myrtle Giddings**
 3. (b) If veteran, name war **/**
 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **6th**
 year **1942** hour **9** minute **02 A.M.**
 21. I hereby certify that I attended the deceased from **6-27-42** to **7-6-42**
 that I last saw her alive on **7-6-42** and that death occurred on the date and hour stated above.

4. Sex **F** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Alfred** 6. (c) Age of husband or wife if alive **53** years
 7. Birth date of deceased **July 4 1890**
 8. AGE: Years **49** Months **0** Days **2** If less than one day hr. min.

Immediate cause of death **Cerebral hemorrhage**
 Duration
 Due to **83a**
 Due to

9. Birthplace **St. Joseph Mo** (City, town, or county) (State or foreign country)
 10. Usual occupation **Homemaker**

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations
 Of autopsy **See above**

MOTHER FATHER
 11. Industry or business
 12. Name **Michel Coppenbayer**
 13. Birthplace **Va**
 14. Maiden name **Mary Wenzel**
 15. Birthplace **Va**

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?
 While at work? (Specify type of place) Means of injury **0**

16. (a) Informant **M. Giddings**
 (b) Address **1925 Monroe**
 17. (a) **Buried** (b) Date thereof **7-9-42**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Funerary**
 18. (a) Signature of funeral director **R. G. Blackburn**
 (b) Address **no**
 19. (a) **7-7-42** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

23. Signature **Wiley R. Horn** (M. D. or other)
 Address **Med. Dir. K.C. Gen. Hospital** Date signed

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

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..... *B. H. Beckman*.....
Licensed Embalmer No. *2244*.....
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.