

7. S. No. 2
 FORM-5-42
 Rev. 5-17-39
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30178

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 19 1942 149

Primary Registration District No. 1002

Registrar's No. 4101

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:
112 North Wheeling
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 13 Years
 (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. 112 North Wheeling
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country: ---

3. (a) PRINT FULL NAME Mrs. Mary Catharine Doherty
 3. (b) If veteran, name war: No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month November day 3rd
 year 1942 hour 7 minute 15 P. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife W. B. Doherty 6. (c) Age of husband or wife if alive: ---- years
 7. Birth date of deceased: February 15 1857
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 15 1938 to 11-3 1942
 that I last saw him alive on 10-31 1942
 and that death occurred on the date and hour stated above.

8. AGE: Years 85 Months 8 Days 16
 If less than one day hr. min.

Immediate cause of death: Cardiac decompensation and failure
 Due to: Arterial sclerosis
 Due to: Senility
 Other conditions: 950
 (Include pregnancy within 3 months of death)

9. Birthplace: Warren Iowa
 (City, town, or county) (State or foreign country)
 10. Usual occupation: At Home

Major findings:
 Of operations: _____
 Of autopsy: _____
 PHYSICIAN: _____
 Underline the cause to which death should be charged statistically.

11. Industry or business: ----
 12. Name: Isaac Beaty
 13. Birthplace: Unknown Ohio
 (City, town, or county) (State or foreign country)
 14. Maiden name: Marshall McCord
 15. Birthplace: Unknown Ohio
 (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant: Mrs. Lillie C. Nurss
 (b) Address: 112 North Wheeling Avenue
 17. (a) Removal (b) Date thereof: Nov. 5, 1942
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: Argyle, Iowa

While at work? _____ (Specify type of place)
 (e) Means of injury: _____
 23. Signature: M. Brown M.D. (M. D. or other)
 Address: 509 Whitman Bldg Date signed: _____

18. (a) Signature of funeral director: O. H. Newcomer's Sons
 (b) Address: 1401 Brush Creek Bldg
 19. (a) 11-5-42 (b) M. Brown
 (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

5242 H. John Avenue
2-5

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 *A. C. Newcomer Jr*
Licensed Embalmer No. 4043
P. O. Address *A. C. Newcomer*

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.