

No. 2  
5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5574

FILED FEB 27 1943  
Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 698

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  
(d) Length of stay: In hospital or institution 3 Mo. & 23 days  
In this community 20 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 3302 E. 14th St.  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Polly Walter  
(b) If veteran, name war no  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 4th  
year 1943 hour 11:05 minute P.M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced M.  
6. (b) Name of husband or wife Joseph H. Walter  
6. (c) Age of husband or wife if alive unk. years

21. I hereby certify that I attended the deceased from 10-12-42 to 2-4-43  
er 2-4-43  
that I last saw h. alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

7. Birth date of deceased June 22 1884  
(Month) (Day) (Year)  
8. AGE: Years 58 Months 7 Days 12  
If less than one day hr. min.

Immediate cause of death Carcinoma of cervix  
Due to 48 hrs

9. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Other conditions (include pregnancy within 3 months of death)  
Due to \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy None

11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Melina Baker  
15. Birthplace Kentucky  
(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 Joe H. Walter  
(b) Address 302 E 14  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-43  
(Month) (Day) (Year)  
(c) Place: burial or cremation Donor, Mo.

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature Dr. R. Shaw (M. D. or other)  
Address Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

18. (a) Signature of funeral director Donor & John  
(b) Address H-G. Mo.  
19. (a) 2-9-43 (Date received local registrar)  
(b) M. M. Brown (Registrar's signature)

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

MOTHER FATHER

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

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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.....

**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.**