

V. S. No. 2
 FORM-2-43
 Rev. 5-17-39
 1 X35697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **40398**
 Registrar's No. **5535**

FILED JAN 5 1943
 Registration District No. **1602**

Primary Registration District No. **1602**

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: St. Marys Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Days
 In this community sev. 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. 812 W. 40th St.
 (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MATTHEW J. GRACE
 (b) If veteran, name war No
 (c) Social Security No. 494-12-3670

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 12 day 24
 year 43 hour 3:45 minute _____ M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widower
 6. (b) Name of husband or wife Harriet Grace
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Apr 4 1871
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ 19____
 that I last saw him _____ alive on _____ 19____
 and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 8 Days 20
 If less than one day _____ hr. _____ min.

Immediate cause of death Fracture of the skull
Separation of the brain
 Due to _____
 Due to _____

9. Birthplace Olathe Kansas
 (City, town, or county) (State or foreign country)
 10. Usual occupation Sheet Metal Worker

Other conditions (include pregnancy within 3 months of death) _____
 Major findings of operations _____
 Of autopsy See above

11. Industry or business _____
 12. Name Michael Grace
 13. Birthplace Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Ellen O'Neil
 15. Birthplace Ireland
 (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) Accident
 (b) Date of occurrence 12/22/43
 (c) Where did injury occur? 812 W 40th St Kansas
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Do not know
 (Specify type of place)
 While at work _____ (e) Means of injury _____
 23. Signature JOSEPH (M.D. or other)
 Address _____ Date signed 12/24/43

16. (a) Informant Miss Evelyn Grace
 (b) Address 812 West 40th St
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 1943
 (Month) (Day) (Year)
 (c) Place: burial or cremation Shawnee Kansas
 18. (a) Signature of funeral director Frank E. Rubin Co
 (b) Address 20 West Linwood
 19. (a) 12-27-43 (b) T. E. Brown
 (Date received local registrar) (Registrar's signature)

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: Charles M. Zwick

Licensed Embalmer No. 3774

P. O. Address. Kansas City, 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.