

S. No. 2
M-3-43
v. 5-17-39
I X37823

6031

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 6 1944

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 904

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: CONVALESCENT HOME #3918 CHARLOTTE STREET
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 MONTHS
(Specify whether in this community years, months or days) 34 YEARS

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. 4826 FLORA AVENUE
(If rural, give location)

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

3. (a) PRINT FULL NAME MRS. MELINDA CATHERINE DOUGHERTY

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 23 1944
year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec. 1943
1943 to Feb-20 1944;
that I last saw her alive on Feb. 20 1944;
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color of race WHITE

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

6. (b) Name of husband or wife MR. SAMUEL DOUGHERTY

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

7. Birth date of deceased APRIL 6 1870
(Month) (Day) (Year)

Immediate cause of death Respiratory Failure Duration Four hrs.

Due to Cerebral Arteriosclerosis yes
gen. arteriosclerosis yes

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
73 10 17 hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name UNKNOWN EARLS

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

14. Maiden name RACHAEL LAMB

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

Major findings: Of operations 97

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Austin R. Brown

(b) Address 5845 Highland

17. (a) BURIAL (b) Date thereof FEB 25 1944
(Burial, cremation, or removal) (City or town) (County) (State)

(c) Place: burial or cremation RICHMOND MISSOURI

18. (a) Signature of funeral director D. W. Newcomer

(b) Address 1401 BRUSH CREEK BLD.

19. (a) 2-25-44 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury _____

23. Signature Harold M. Roberts (M. D. or other) MD
Address 1103 Grand, KCMO Date signed 2-23-44

(Licensed Embalmer's Statement on Reverse Side)

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

1600 Professional Bldg
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 Emile M. Calhoun
Licensed Embalmer No. 3506
P. O. Address FCMO

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.