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

36699

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 4 1944

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4639

**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: ~~Wesley Hosp.~~ Osteopathic Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution week 0 (Specify whether
In this community 3 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City 93
(If outside city or town limits, write "RURAL")
(d) Street No. 825 Packard 14
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Ruby Ann Feighner
3. (b) If veteran, name war no
3. (c) Social Security No. 499-14-1406
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Mar.
6. (b) Name of husband or wife John Feighner
6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased 6 (Month) 15 (Day) 1919 (Year)

8. AGE: Years 25 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Johnson Co. (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John Lure
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Lure
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant John Feighner
(b) Address 825 Packard
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hill Cem
18. (a) Signature of funeral director H. H. Daniels
(b) Address 7th & Kan K. C. Kans.
19. (a) 11-18-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 11 day 15 year 44 hour 5 minute 20 P.M.
21. I hereby certify that I attended the deceased from 8-1, 1944 to Nov. 15, 1944 that I last saw her alive on Nov. 15, 1944 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Pulmonary Embolism | 3 min. |
| Due to Post operative Thyroidectomy | 10 day |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations 63 d' | |
| Of autopsy | |

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

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Faith H. Miller (M. D. or other) CO
Address 4712 1/2 E. 24th Date signed 11/17/44

(Licensed Embalmer's Statement on Reverse Side)

## 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 Augustus C. Werner

Licensed Embalmer No. 2597

P. O. Address 1734 Washington B

Kansas City, Kansa

**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.**