

No. 2
I-5-43
5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1424

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 457

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:
3640 Askew
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 2 years
years, months or days

3. (a) PRINT FULL NAME Mrs Minnie E. Scott

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race Wh

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Oct 11th 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>3</u>	<u>18</u>	hr. _____ min.

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

10. Usual occupation Home

11. Industry or business _____

12. Name J. Wise

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

14. Maiden name Sarah A. Rake

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

16. (a) Informant Mrs Hazel Burns

(b) Address 3640 Askew Kansas City Mo

17. (a) Removal (b) Date thereof I-29-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Villisca Iowa

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address Kansas City Missouri

19. (a) 1-29-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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. 3640 Askew
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29th
year 1945 hour 6 minute 20 A. M.

21. I hereby certify that I attended the deceased from Jan 30, 1944 to Jan 29, 1945
that I last saw her alive on Jan 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of bladder with pelvic metastases

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 A. J. Spafford (M. D. or other) _____
Address Prigg St. Kansas City Mo Date signed 1-29-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

Dr Allen Spafford
Prof Bg
V1 4425
4628 Mission Rd
Va 5463

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

Allen E. Heck

Licensed Embalmer No. *4063*

P. O. Address *1800 Linwood Rd*

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.