V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5122

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 870

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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 Joseph Hosp O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether years, months or days) In this community 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City Ks 801 (If outside city or town limits, write "RURAL")
(d) Street No. 5120 Parish 14 (If rural, give location)
(e) Citizen of foreign country? (Yes or No) O
If yes, name country

3. (a) PRINT FULL NAME Mariah Ellen Courtright
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Frank M Courtright
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 20 1856 (Month) (Day) (Year)

8. AGE: Years 88 Months 2 Days 0 If less than one day hr. min.

9. Birthplace (City, town, or county) Illinois (State or foreign country)
10. Usual occupation at home
11. Industry or business
FATHER
12. Name Norman Hobart
13. Birthplace (City, town, or county) Ill (State or foreign country)
MOTHER
14. Maiden name Uria Halliday
15. Birthplace (City, town, or county) Ill (State or foreign country)
16. (a) Informant Mrs Lucy Brink
(b) Address 4625 Genesee
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 23 45 (Month) (Day) (Year)
(c) Place: burial or cremation Hutchinson Kans
18. (a) Signature of funeral director Mrs. C L Forster
(b) Address 918 Brooklyn
19. (a) 2-22-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1945 hour minute 11:15 P.M.
21. I hereby certify that I attended the deceased from Feb 14, 1945, to Feb 20, 1945; that I last saw her alive on Feb 20, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure
Due to Generalized arteriosclerosis
Due to
Other conditions (Include pregnancy within 3 months of death) 97
Major findings: Of operations —
Of autopsy As above

Duration

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 Maine Sherwood, (M. D. ~~or other~~)
Address Pathologist Date signed 2-21-45

(Licensed Embalmer's Statement on Reverse Side) St. Joseph Hospital, K.C., Mo.

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 J. V. Herrick

Licensed Embalmer No. 38-99

P. O. Address K C 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.