

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9560**  
Registrar's No. **1423**

Registration District No. **FILED APR 1 1946**

Primary Registration District No. **1002**

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:  
**General Hospital No. 10**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days**  
(Specify whether)

In this community **unknown**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri**

(b) County **Jackson 48**

(c) City or town **Kansas City 3**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3200 Norledge 8**  
(If rural, give location)

(e) Citizen of foreign country? **0**  
(Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Mary Monti**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

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 **unknown**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **23**  
year **1946** hour **9** minute **50 A.** M.

21. I hereby certify that I attended the deceased from **March 19**, 19**46** to **March 23**, 19**46**  
that I last saw her alive on **March 23**, 19**46**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**about 71.** hr. min.

Immediate cause of death **Senility**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation **none**

11. Industry or business \_\_\_\_\_

Other conditions **162 16**  
(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace **unknown 9**  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace **unknown 9**  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy **None**

16. (a) Informant **H. C. Convalescent Home**

(b) Address **3200 Norledge**

17. (a) **Burial** (b) Date thereof **3-27-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Quintin Robin**

(b) Address **202 W Genwood**

19. (a) **3-25-46** (b) **Seraldine Holmes**  
(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 **Wm W Hart M.D.** (M.D. or other)  
Address **Med. Dir. Gen'l Hosp.** Date signed **3-25-46**

*Ch. M. Quirk*

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**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. Quirk* .....

Licensed Embalmer No. *3774* .....

P. O. Address *K. E. 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.**