

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30359**
Registrar's No. **4132**

FILED OCT 14 1946

Registration District No. 149 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. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 23 days
(Specify whether
In this community 7 yrs
years, months or days)

3. (a) PRINT FULL NAME Sadie Marr
3. (b) If veteran, name war - no 3. (c) Social Security No. none

4. Sex F 5. Color or race W 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 May 3 - 1859
(Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Clay Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business Retired house wife

MOTHER FATHER

12. Name John B. Selley
13. Birthplace Jamestown Va
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Crawford
15. Birthplace Va
(City, town, or county) (State or foreign country)

16. (a) Informant Clyde Jones
(b) Address 3004 Grand, K.C. Mo
17. (a) Buried (b) Date thereof 10-2-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blue Springs Mo

18. (a) Signature of funeral director Wm G. Webb, Sr.
(b) Address Blue Springs Mo

19. (a) 9-30-46 (b) Alfredine Holme
(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. 3004 Grand
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 30
year 1946 hour 5 minute 20 A.M.
21. I hereby certify that I attended the deceased from Aug. 7, 1946 to Sept. 30, 1946
that I last saw her alive on Sept. 30, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 95

Major findings:
• Of operations _____
• Of autopsy None
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Brandon Hull (M. D. or other) 9-30-46
Address Med. Dir. Gen'l Hosp. Date signed _____

Dr. M. ...

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..... *R. B. Webb*

Licensed Embalmer No. *2353*

P. O. Address..... *Blue Springs, 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.