

**FILED DEC 9 1946**  
199

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36975

State File No. \_\_\_\_\_

4959

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

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: 5015 Paseo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no. (Specify whether  
In this community life (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Marcellette Grant

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex female / 5. Color or race white 6. (a) Single widowed, married, divorced. child

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased June 24 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
5 5 27 hr. min.

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

10. Usual occupation child

11. Industry or business X

12. Name L. C. Grant

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

14. Maiden name Betsy Sawyer

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

16. (a) Informant Mrs. L. C. Grant

(b) Address 5015 Paseo, Kansas City, Mo.

17. (a) Cremation (b) Date thereof 11-26-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 11-26-46 (b) Alfredine Stine  
(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. 5015 Paseo  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24  
year 1946 hour 11:30 minute A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw her alive on 1 October, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Brain Tumor  
Due to probably malignant

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 546

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

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature J. H. Carmichael, Jr. (M. D. or D.O.)  
Address 726 Bldg. Date signed 25 Nov

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

Dr. Carmichael?

Mr. B. B. B.

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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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address 14c. 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.