

S. No. 2  
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 S-17-39  
 X47070

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
**FILED MAR 10 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

4803  
 State File No. \_\_\_\_\_  
 929  
 Registrar's No. \_\_\_\_\_

Registration District No. 149 Primary Registration District No. 1002

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

**1. PLACE OF DEATH:** Jackson  
 (a) County.....  
 (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 4 days  
(Specify whether  
 In this community 3 Years  
years, months or days)

3. (a) PRINT FULL NAME Mary Doak  
 3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Novia Doak 6. (c) Age of husband or wife if alive \* 1886 years  
 7. Birth date of deceased 12 6 1886  
(Month) (Day) (Year)

8. AGE:			If less than one day	
Years	Months	Days	hr.	min.
60	2	21		

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_  
 12. Name Phillip Eennett  
 13. Birthplace Iowa  
(City, town, or county) (State or foreign country)  
 14. Maiden name Jeanetta Fitzpatrick  
 15. Birthplace Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Irene Doak  
 (b) Address 3506 East 25th. Street

17. (a) Burial (b) Date thereof 3-1-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery Idep.

18. (a) Signature of funeral director Mrs. C. L. Forster  
 (b) Address Kansas City, Missouri

19. (a) 3-1-47 (b) Sheldine Holmes  
(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. 3506 E. 25 St.  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Feb. day 27  
 year 1947 hour 8 minute 35 A.M.

21. I hereby certify that I attended the deceased from Feb. 24 19 47 to Feb. 27 19 47  
 that I last saw her alive on Feb. 27 19 47  
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia  
 Duration \_\_\_\_\_

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

Other conditions 108  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy See above  
 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) (e) Means of injury

23. Signature Wm W. Ward (M. D. or other) M.D.  
 Address Med. Dir. Gen'l Hosp. Date signed 2-27-47

*R. K. ...*  
*...*

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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 *L. H. Niece*

Licensed Embalmer No. *25-90*

P. O. Address *K. O. Niece*

**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.**