

No. 2
-12-45
5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8955**

FILED APR 1 1947

Registration District No. **199**

Primary Registration District No. **1002**

Registrar's No. **1201**

1. PLACE OF DEATH:

(a) County **Jackson, Kansas**
(b) City or town **Kansas City, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **General Hospital #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 hours** (Specify whether
In this community **unknown** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Kansas City, Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **2814 E 33rd**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Cain, Kate

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 **widowed**

6. (b) Name of husband or wife **Walter Cain**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 21 1872**
(Month) (Day) (Year)

8. AGE: Years **74** Months **7** Days **22**
If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **unknown**

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

14. Maiden name **"**

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

16. (a) Informant **Mrs. Nadine Shedd**
(b) Address **430 W. 60th Ave.**

17. (a) **Removal** (b) Date thereof **3-16-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Omaha Neb.**

18. (a) Signature of funeral director **Blackman & Sons**
(b) Address **Kansas City Mo**

19. (a) **3-16-47** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3-15** Day **47**
year _____ hour **5** minute **45** P.M.

21. I hereby certify that I attended the deceased from **3-15-47**
10:50am 19____ to **3-15-47** 19____
that I last saw her alive on **3-15-47** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho pneumonia**
Acute ulcerative endocarditis
rheumatic Heart disease
Due to _____

Due to _____
Other conditions? **95%**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **as above**

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. or other) **MD**
Address **Med. Dir. Gen'l Hosp.** Date signed **3-16-47**

48
3
8
0

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

MOTHER FATHER

Dr. J. H. Williams

24 5-18-6

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 *O. K. McFarland*

Licensed Embalmer No. *4397*

P. O. Address *Kansas City 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.