

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: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 9 weeks
(Specify whether In this community 9 weeks years, months or days)

3. (a) PRINT FULL NAME..... EDNA MAY GAW

3. (b) If veteran, name war..... no 487 Sec 59 998

4. Sex..... fe 5. Color or race..... white

6. (a) Single, widowed, married, divorced..... wid

6. (b) Name of husband or wife..... Thomas J. 6. (c) Age of husband or wife if alive..... 67 years

7. Birth date of deceased..... August 31 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74 11 10 hr. min.

9. Birthplace..... Park Co. Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... John J. Blake

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

14. Maiden name..... Harley Boose

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

16. (a) Informant..... Mrs. Lucile Key

(b) Address..... Modesto Calif.

17. (a) Burial (b) Date thereof..... 8-13 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Mt. Moriah

18. (a) Signature of funeral director..... C.H. Blackman & Son Inc.

(b) Address..... 2825 Independence Blvd.

19. (a) 8-13-47 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... California (b) County..... 999

(c) City or town..... Oakland
(If outside city or town limits, write "RURAL") 14

(d) Street No..... 0
(If rural, give location) 2

(e) Citizen of foreign country? no (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... August day..... 11
year..... 1947 hour..... 8 minute..... 15 A. M.

21. I hereby certify that I attended the deceased from..... June 12 1947 to..... Aug 11 1947
and that I last saw her alive on..... Aug 10 1947
and that death occurred on the date and hour stated above.

Immediate cause of death..... Lympho sarcoma involving
Colon, stomach, retroperitoneal and mediastinal glands, neck, diaphragm, pectoral muscles, breast also
lesions overlying these areas
Duration 8-1947
Symptoms from June 12-1947

Due to..... Colon, stomach, retroperitoneal and mediastinal glands, neck, diaphragm, pectoral muscles, breast also lesions overlying these areas

(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: None

Of operations.....

Of autopsy..... Same as above

Underline the cause of 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)

Means of injury.....

23. Signature..... W. R. Ferris (M. D. or other)

Address..... 934 Argyle Bldg
Kansas City, Mo

Date signed..... Aug 12 1947

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

MOTHER FATHER

APR 12 1954

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 C. K. McFarland

Licensed Embalmer No. 4399

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.

3-2B
3-45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 2 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3454

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: Research Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Edna May Saw

3. (b) If veteran, name war _____

3. (c) Social Security No. 487-05-9981

4. Sex _____

5. Color or race _____

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day

_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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 _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-12-47 (Date received local registrar) Geraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1947 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

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

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)

(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

50227701

FILED OCT 4 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3454

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Edna May Gaw

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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 _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-12-47 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 11
year 1947 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from June
12 1947, to August 11 1947
that I last saw her alive on August 10 1947
and that death occurred on the date and hour stated above.
Immediate cause of death _____

lympho sarcoma involving symptoms
colon, stomach, retroperitoneal & from
mediastinal glands, right 6-8-47
diaphragm pectoral muscles, breasts
and skin overlying these areas
primary in colon

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

Major findings: Of operations none 400

Of autopsy same 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 Carl R. Ferris (M. D. or other) _____
Address 934 Argyle Bldg Date signed 8-12-47

SUPPLEMENTARY

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

S- (A) 27201