No. 2
M—2-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 19 1947

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 27833

Registrar's No. 3340

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: The Willows 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 29 days (Specify whether years, months or days)
In this community 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2929 Main 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Cynthia Maynard

3. (b) If veteran, name war ~~Infant~~ no

3. (c) Social Security No. none

4. Sex Female 1

5. Color or race Wh.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 6 (Day) 1947 (Year)

8. AGE: Years | Months | Days 29 | If less than one day hr. min.

9. Birthplace Kansas City, Jackson County, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business 9

FATHER
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Clements Maynard
15. Birthplace St. Paul Minnesota 1
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Clements Maynard
(b) Address 2929 Main Street, K. C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cemetery

18. (c) Signature of funeral director Wilks Funeral Home
(b) Address 2315 Linwood K. C. 3 Mo

19. (a) 8-6-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th year 1947 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 6th 1947 to August 4 1947 that I last saw her alive on August 4th 1947 and that death occurred on the date and hour stated above.

Immediate cause of death prematurity	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 159	

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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature H. Dwyer (M. D. or other)
Address 315 Alameda Rd. Date signed 8-5-47

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.