S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 8 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34429

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4522

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: St Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3420 Benton 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Eddie F Cummings
3. (b) If veteran, name war NO
3. (c) Social Security No. NO
4. Sex Fem
5. Color or race Wh
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Wesley Cummings
6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased Feb (Month) 2 (Day) 1859 (Year)

8. AGE: Years 88 Months 8 Days 25 If less than one day hr. min.

9. Birthplace Kansas (City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business
MOTHER FATHER
12. Name Wallack
13. Birthplace Ohio (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant N. W. BAILEY
(b) Address 1817 W 50 ST.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/28/47 (Month) (Day) (Year)
(c) Place: burial or cremation EFFINGHAM KS.
18. (a) Signature of funeral director Stine-McClure
(b) Address Kansas City, Mo
19. (a) 10-29-47 (Date received by registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27 year 1947 hour 12 minute 15 P.M.
21. I hereby certify that I attended the deceased from Crown, 19, to, 19; that I last saw h. alive on, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia
Due to Fractured Right hip
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy no
Autopsy & Inspection

Duration

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) accident
(b) Date of occurrence 10-25-47 123
(c) Where did injury occur? K.C. Jackson Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Convalescent Home (Specify type of place)
While at work? no (e) Means of injury fall
23. Signature (M. D. or other)
Address Date signed 10-28-47

(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 Robt H Reed

Licensed Embalmer No. 3745

P. O. Address K. C. 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.