

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **199**

Primary Registration District No. **1002**

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

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:
3937 Washington
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **50 Years**
(Specify whether years, months or days)

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. **3937 Washington**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Mrs. Grace Stewart White**

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 **Widowed**

6. (b) Name of husband or wife **Peter White**

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

7. Birth date of deceased **Dec. 24 1871**
(Month) (Day) (Year)

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

76 **3** **10** hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Dont Know**

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

14. Maiden name **Dont Know**

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

16. (a) Informant **Homer C. White**

(b) Address **Chicago, Ill.**

17. (a) **Burial** (b) Date thereof **4/6/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Mo.**

19. (a) **4-5-48** (b) **Steraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **4**
year **1948** hour **9** minute **15 A.** M.

21. I hereby certify that I attended the deceased from **MARCH**
1947 to **4-4** 19**48**
that I last saw **her** alive on **4-3-** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Lobar PNEUMONIA** Duration **2 days**

Due to **Metastatic CARCINOMA 1-4R. OF UNDETERMINED ORIGIN (m.m.o.)**

Due to **MYOCARDIAL INFARCTION 5-10 YRS. + DEGENERATION**

Other conditions **SENILITY**
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations **552**

Of autopsy **NONE**

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)

Mean of injury **2**

23. Signature **Roy V. Guss, DR.** (M.D. or other) _____
Address **500 Bryant Bldg.** Date signed **4-4-48**

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..... *Elmer C. Wedelin*.....
Licensed Embalmer No. *3495-*.....
P. O. Address..... *J. 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.