

No. 300
1-10-47
5-17-39
I 3908

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

26132

State File No. _____

FILED SEP 4 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3494

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: Lindeman Convalescent Home 4
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 2 years
(Specify whether In this community 45 years years, months or days)

3. (a) PRINT FULL NAME Miss Mary L. Bair

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 Single

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

7. Birth date of deceased July 15th. 1867
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin Bair

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

14. Maiden name Miherva Criley

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

16. (a) Informant Walter L. Criley

(b) Address 3014 Montgall

17. (a) Removal (b) Date thereof 8-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mansfield, Ohio

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) 8-27-48 (b) Geraldine Volbre
(Date received local registrar) (Registrar's signature)

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. 708 Corbin Terrace 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26th. year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from March 5, 1947 to Aug. 26, 1948
that I last saw her alive on Aug. 26, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral hypostatic pneumonia.

Due to Cerebral hemorrhage

Due to _____

Other conditions Senility & general arteriosclerosis.
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy ()

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) _____

(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 Donna O. O'Leary (M. D. or other) 200

Address 407 W. 34th St. Date signed 8-27-48

Winthrop Bldg.
Tue. A.M. 018
19

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 *Willis J. Bennett*

Licensed Embalmer No. *4438*

P. O. Address *H. C., 7122*

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.