

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

33951

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4486</u>		
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (In this place) <u>40 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>				d. STREET ADDRESS (If rural, give location) <u>315 W. 9 St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u>		b. (Middle) <u>G.</u>		c. (Last) <u>Mumford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 18 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 30, 1868</u>		
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR <u>10</u> Months <u>18</u> Days		IF UNDER 1 HRS. <u>0</u> Hours <u>18</u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Crane Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Sheffield Steel Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>St. Joseph, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Mumford</u>			13b. MOTHER'S MAIDEN NAME <u>Loretta Gates</u>			14. NAME OF HUSBAND OR WIFE <u>Bell R. Mumford</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Ira J. Mumford, 3403 Flora, K.C., Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular accident</u>								
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES						
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						
		DUE TO (b) _____						
		DUE TO (c) _____						
		II. OTHER SIGNIFICANT CONDITIONS						
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture left hip</u>						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City, Jackson, Missouri</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10 3 1949 P.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall</u>				
22. I hereby certify that I attended the deceased from <u>Oct. 3</u> , 19 <u>49</u> , to <u>Oct. 18</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Oct. 18</u> , 19 <u>49</u> , and that death occurred at <u>11:55 P.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Wm. W. Hart</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Med. Dir. Gen'l Hosp.</u>		23c. DATE SIGNED <u>10-19-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-22-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10-20-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mellody-McGilley-Eylar, K.C., Mo.</u>				

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

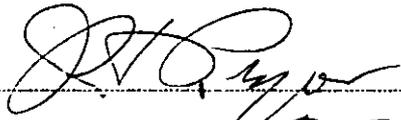
A. M. M. M.

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.....

....., Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed 
Licensed Embalmer No. 2989
P. O. Address KC

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.