

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40195

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1400

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital		d. STREET ADDRESS (If rural, give location) 7419 Wayne Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Laura		b. (Middle) May	
c. (Last) Black		4. DATE OF DEATH (Month) (Day) (Year) December 20, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 2, 1870
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ****	
11. BIRTHPLACE (State or foreign country) Iowa.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Robert Thomas Scott COLE		13b. MOTHER'S MAIDEN NAME Susan McKisack	
14. NAME OF HUSBAND OR WIFE William Black			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Anna McKinley		ADDRESS St. Joseph, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Endocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Nephritis DUE TO (c) Selinity II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 20, 1949 , to Dec. 20, 1949 , that I last saw the deceased alive on 12-20, 1949 , and that death occurred at 11:31 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature]		23b. ADDRESS 623 Faron St. St. Joseph, Mo.	
23c. DATE SIGNED 12-20-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 22, 1949	
24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.	
DATE REC'D BY LOCAL REG. Dec. 22, 1949		REGISTRAR'S SIGNATURE E. B. Jenkins	
FUNERAL DIRECTOR'S SIGNATURE Hatter Meierhoffer		ADDRESS 1946 Colhoun St. St. Joseph, Mo.	

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 *Albert C. Harrington*

Licensed Embalmer No. 3258 Missouri.

P. O. Address St. Joseph, Missouri

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.