

FILED NOV 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37589

State File No. 4734

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4734

1. PLACE OF DEATH a. COUNTY Jackson		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 township) OR TOWN Kansas City	c. LENGTH OF STAY (in this place) 36 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3400 Drury (Home)		d. STREET ADDRESS (If rural, give location) 3400 Drury	

3. NAME OF DECEASED (Type or Print) Mollie	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH Nov-2-1951	(Month)	(Day)	(Year)
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH April-25-68	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Travis County Texas	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME San Fowler	13b. MOTHER'S MAIDEN NAME Amanda Costley	14. NAME OF HUSBAND OR WIFE Fred Smith (Deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Robert Fowler	ADDRESS 3400 Drury
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 15 hr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cachexia and Bronchopneumonia		
	ANTECEDENT CAUSES DUE TO (b) Carcinoma of Stomach DUE TO (c) " "		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-11-51, 19, to 11-2-51, 19, that I last saw the deceased alive on 1-2-21, 19, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE George H. Hart	23b. ADDRESS 2204 E. 18th st.	23c. DATE SIGNED 11-5-51
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24a. BURIAL, CREMATION, TOMB REMOVAL (Specify) Burial	24b. DATE 11-7-51	24c. NAME OF CEMETERY OR CREMATORY Lincoln	24d. LOCATION (City, town, or county) (State) Kansas City mo
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DATE REC'D BY LOCAL REG. 11-6-51	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE West, Appleton & Jones	ADDRESS N.C. mo
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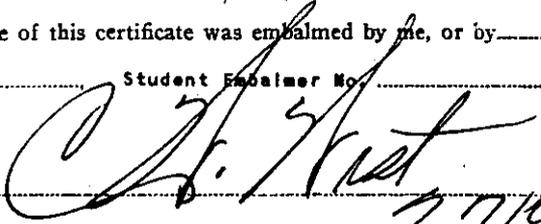
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student
Student Embalmer

Signed 
Student Embalmer No. _____
Licensed Embalmer No. 2710
P. O. Address R. C. 270

-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.