

REC'D FEB 20 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1316
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395
(b) Township Kaw Primary Registration District No. 1002
(c) City Kansas City, Mo. (d) Street No. 331 N. Lawndale St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 329

2. PRINT FULL NAME

300 Mrs. Ida Todd
(a) Residence, No. 331 N. Lawndale St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF H. M. Todd		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 21, 1867		
7. AGE	YEARS	MONTHS
	71	6
		3
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois		
FATHER	13. NAME Anthony Ferguson	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown	
MOTHER	15. MAIDEN NAME Unknown	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown	
17. INFORMANT (ADDRESS) Raymond A. Todd 331 N. Lawndale, K.C. Mo.		
18. BURIAL, CREMATION, OR REMOVAL PLACE Mechanicburg, Ill DATE Jan. 26-39 19 39		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) C.H. Slackman & Son, Inc. 2825 Indep. Blvd. K.C. Mo.		
20. FILED Jan 25 19 39 M. M. Brown Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 24, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **Nov. 10**, 19**38**, to **Jan. 24**, 19**39**

I last saw her alive on **Jan. 21**, 19**39**. Death is said to have occurred on the date stated above, at **3 A.** m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Breast Date of onset **5 yrs**
50

Other contributory causes of importance:

Metastases to lungs and eyes plus.

Name of operation **Breast Amputation** Date of **1939**What test confirmed diagnosis? Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19**39**

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No**

If so, specify

(Signed) **Joseph E. Walker** M. D.(Address) **836 Professional Bldg**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1:30 4:11 4:30

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.