DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Board of Health

State File No. 31362

Registration District No. 399 — OCT 18 1939

Primary Registration District No. 1002

Registrar's No. 3460

1. PLACE OF DEATH: Jackson

(a) County 1

(b) City or town Kansas City, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital K. C. M. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One Day (Specify whether years, months or days) In this community 3 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 1

(c) City or town Kansas City, Missouri. (If outside city or town limits, write "RURAL")

(d) Street No. 1116 Prospect Avenue, K.C. Mo. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Betty J. Maddux 320

3. (b) If veteran, name war ✓ No

3. (c) Social Security No. ✓ No

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 Sept. 23 1936 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
2	11	9	hr. min.

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

10. Usual occupation --------

11. Industry or business --------

FATHER
12. Name Edgar R. Maddux
13. Birthplace Hamilton, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Edith M. Harlow
15. Birthplace Carrolton, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edgar R. Maddux,

(b) Address 1116 Prospect Avenue, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5th, 39 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Mrs. C.L.Forster

(b) Address Kansas City, Mo.

19. (a) 9/4/39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2nd, 1939 year 1939 hour minute 8:20 P.M.

21. I hereby certify that I attended the deceased from ..... to ....., 19...; that I last saw the ..... alive on ....., 19...; and that Deputy Coroner occurred on the date and hour stated above.

Immediate cause of death ✓ Lobular pneumonia

Due to

Due to

Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Victor W. Fuhler (M. D. or other)

Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

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.

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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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address 918 Brooklyn R. C. M

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.

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.

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

Do not use this space. X

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 31462
Township — Primary Registration District No. 1002 — Registered No. 3460
City K. C. (No. Gen. Hosp. St. Ward)

2. FULL NAME Betty J. Maddox
(a) Residence, No. St. Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS 2 MONTHS 11 DAYS 9 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19
19. UNDERTAKER (ADDRESS)
20. FILED 9/4 1939 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 2, 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobular Pneumonia Primary	

Other contributory causes of importance: 1070

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
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? .....
If so, specify .....
(Signed) Victor B. Buhler, M. D.
(Address) K. C. Mo.

SUPPLEMENTARY