DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
OCT 18 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31382

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3480

1. PLACE OF DEATH: 2

(a) County Jackson

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

(c) Name of hospital or institution: 6036 Agnes ave (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether

In this community 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County Jackson

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

(d) Street No. 6036 Agnes ave (If rural, give location)

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

3. (a) PRINT FULL NAME Mrs Nancy True 6 A-D

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Fe

5. Color or race wh

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Hash James R. True

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Oct (Month) 28th (Day) 1852 (Year)

8. AGE: Years 86 Months 10 Days 6 If less than one day hr. min.

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

10. Usual occupation Housewife 1

11. Industry or business ✓

FATHER
12. Name Firebaugh 9
13. Birthplace Not Known 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not Known
15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Delta Pullins

(b) Address 6036 Agnes

17. (a) Memorial Park (Burial, ~~cremation, or removal~~) (b) Date thereof 9 - 6 1939 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ Memorial Park Cem

18. (a) Signature of funeral director W. F. Mayberry KS Kas

(b) Address Kansas City Mo

19. (a) 9 - 5/39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4th year 1939 hour 12 minute 15 P M.

21. I hereby certify that I attended the deceased from Jan, 1939, to Sept 4, 1939; that I last saw her alive on Sept 3, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac failure Chronic Myocarditis	
Due to Arteriosclerosis 93C	
Due to Senility	
Other conditions Dehydration (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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) No

(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 Paul C. Platt (M. D. ~~or other~~)

Address 612 Professional Bldg Date signed Sept 4, 39

(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.

Rev. 5-17-39 I X19511

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 R. E. Snow, Registered ~~Apprentice~~ Emb. No. 2560, working under my personal supervision.

Signed W. J. Mayberry

Licensed Embalmer No. 2934

P. O. Address Kansas City Mo.

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.