

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

REV. 8-17-39 I X1951

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38783
Registrar's No. 4547

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson 2
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1617 Tracy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Laura B. Kay

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Fe 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sanford S. Kay 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased December 25, 1875
(Month) (Day) (Year)

8. AGE: Years 63 Months 11 Days 2 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business 0

12. Name Alfred McClanahan 1

13. Birthplace Texas 4
(City, town, or county) (State or foreign country)

14. Maiden name Temple

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sanford Kay
(b) Address 1617 Tracy

17. (a) burial (b) Date thereof 11-30-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Watkins Bros.
(b) Address 1729 Lydia

19. (a) Nov. 29, 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1617 Tracy (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27th
year 1939 hour _____ minute 4:30 A. M.

21. I hereby certify that I attended the deceased from 8-25-39
_____, 19____, to 11/27, 1939
that I last saw her alive on 11/27, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 3 days

Due to Arteriosclerosis

Due to 82

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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? _____

While at work? (Specify type of place) _____
(a) Means of injury 1

23. Signature M. D. (M. D. or other) M. D.
Address 1618 Lydia Date signed 11/29/39

Duration
Physician
Underline the cause to which death should be charged statistically

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 Isaac Jerome Menlove

Licensed Embalmer No. 3994

P. O. Address 1120 E. 23rd St.

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.