

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 42442
Registrar's No. 4851Registration District No. 399Primary Registration District No. 1002

1. PLACE OF DEATH:

(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: K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT
FULL NAMEMary McCave 2103. (b) If veteran,
name war No3. (c) Social Security
No. Unk.4. Sex F 5. Color or
race W 6. (a) Single, widowed, married,
divorced Single6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased Unknown
(Month) (Day) (Year)8. AGE: Years App. 60 Yrs. Months _____ Days _____ If less than one day
hr. _____ min. _____9. Birthplace Unknown
(City, town, or county) (State or foreign country)10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Record Office(b) Address St. Mary's Hosp.17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Mary's Hosp.18. (a) Signature of funeral director Daniel J. John Co.(b) Address 20 W. Ashwood19. (a) Dec 24, 1939 (b) Monahan
(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. 1312 Summit
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23rd
year 1939 hour 7 minute 45 A. M.21. I hereby certify that I attended the deceased from 11-21-
1939, to 12-23-39, 19____;
that I last saw her alive on 12-23-39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic myocarditis with myocardial
insufficiency

Due to _____

Due to _____

Other conditions Hypostatic bronchopneumonia
(Include pregnancy within 3 months of death)Major findings:
Of operations _____Of autopsy None

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) (e) Means of injury _____23. Signature P. J. J. Mans MD (M. D. or other)
Address Supt. K.C. Gen. Hospital, K.C., Mo. signed _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically

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.....

Harold V. Perry, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 4097

P. O. Address 20 W. Lincoln
St. Louis, 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.