

BUREAU OF THE CENSUS  
JAN 13 1940MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42560

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4969

## 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 1.0. & 13 days  
 (Specify whether  
 In this community 59 years  
 years, months or days)

3. (a) PRINT FULL NAME Sally M. McDaniels 2353. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife CHAS. E. MCDANIELS 6. (c) Age of husband or wife if alive 64 years  
 7. Birth date of deceased FEB. 29 1880  
 (Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 1 If less than one day hr. min.9. Birthplace JACKSON COUNTY MO.  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife 011. Industry or business Home 012. Name Frank Carson13. Birthplace BUCKNER MO.  
(City, town, or county) (State or foreign country)14. Maiden name Susie Penrose15. Birthplace BLUE SPRINGS MO.  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature CHAS. E. MCDANIELS(b) Address 6421 EAST 14TH17. (a) REMOVAL (b) Date thereof JAN. 2 19  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation BLUE SPRINGS, MO.18. (a) Signature of funeral director SHEIL FUNERAL MO.(b) Address 6606 INDEPENDENCE, K.C.M.19. (a) Dec. 31 1939 (b) M. M. Crowe  
(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. 6421 E. 14th St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30th  
year 1939 hour 11 minute 30 A. M.21. I hereby certify that I attended the deceased from  
Nov. 17th 1939 to Dec. 30th 1939  
that I last saw him alive on Dec. 30th, 1939  
and that death occurred on the date and hour stated above.Immediate cause of death  
Diffuse myocardial fibrosis and  
cardiac hypertrophy and ascites  
Due to Chronic passive congestion of  
liver with cirrhosis and varices of  
oesophagus and stomach  
Due to \_\_\_\_\_Other conditions Right hydrothorax  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy See above

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. Williams M.D. (M. D. or other)  
Supt. K.C. Gen. Hospital, Date Jan. 2,Address \_\_\_\_\_ Date 5990

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.....

JOE B. Yoder, Registered Apprentice No. # 233  
working under my personal supervision.

Signed

John Sheil

Licensed Embalmer No. # 3625

P. O. Address K. C. 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.**