

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.

FILED FEB 26 1940

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

1393  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township 0 Primary Registration District No. 1002  
 (c) City Kansas (d) Street No. Wesley Hospital Registered No. 378  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred  yrs. - mos. 10 da. (f) How long in U.S., or of foreign birth?  yrs. mos. da.

2. PRINT FULL NAME Mattie B. George 620  
 (a) Residence, No. Gunn City, Mo. St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wray George

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 13-1887

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>52</u>	<u>10</u>	<u>13</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. home-maker  
 9. Industry or business in which work was done, as 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) Kingsville Mo.

FATHER 13. NAME J. P. Kennedy  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk

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

17. INFORMANT (ADDRESS) Wray George Gunn City Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Gunn City Mo. DATE 1/26/40  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Harrisonville Mo  
 20. FILED Jan 26, 1940 W. C. McConr Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 26 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1940 to Jan 26 1940  
 I first saw her alive on Jan 26, 1940 Death is said to have occurred on the date stated above, at 7 P. M.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary embolism Date of onset 1-26-40  
 Other contributory causes of importance: Hypertension  
 Name of operation Hysterectomy Date of 1-17-40  
 What test confirmed diagnosis? obstruction Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury no, 19 24  
 Where did injury occur? no (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. no

Manner of injury no  
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify no  
 (Signed) J. F. Mackery, M. D.  
 (Address) Kansas City, Mo

11/1/12

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 \_\_\_\_\_

*Ernest Rummelburger*

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

1898  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. ....  
 (b) Township R. C. Primary Registration District No. .... Registered No. 378-  
 (c) City R. C. (d) Street No. .... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
52 10 13

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12/31, 1940 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 26, 1940

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him 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:

Pulmonary embolism Date of onset

systemic fibrosis

Other contributory causes of importance:

hypertension

myocardial fibrosis

Name of operation Date of 1-12-40

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) J. F. Mackey, M. D.  
 (Address) R. C. Mo.

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

