

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

Rev. 5-17-39 I X19511

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.

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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: 3611 Bellefontaine  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None (Specify whether  
In this community 40 years years, months or days)

3. (a) PRINT FULL NAMES Susan Margaret Dyer

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Fem 5. Color or race Wh 6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 3 - 1850  
(Month) (Day) (Year)

8. AGE: Years 89 Months 4 Days 27 If less than one day hr. - min.

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

10. Usual occupation Housekeeper

11. Industry or business Home

12. Name Emmanuel Dyer

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

14. Maiden name Wenetta Jacobs

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

16. (a) Informant's own signature Wm M Dyer

(b) Address 3611 Bellefontaine

17. (a) Buried (b) Date thereof 2-1-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Rosa Henderson

(b) Address 15 Jackson - City

19. (a) Jan. 31, 1940 (b) W. 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. 3611 Bellefontaine  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-30-40 day 10 year \_\_\_\_\_ hour \_\_\_\_\_ minute 45 P. M.

21. I hereby certify that Crowe attempted the deceased from 10-11, 19\_\_\_\_; that I last saw alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Chronic myocarditis  
Due to Senility  
Due to 93

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City) \_\_\_\_\_ (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) (Specify nature of injury) \_\_\_\_\_

23. Signature W. M. Crowe (M. D. or other) \_\_\_\_\_  
Address K. C. Mo Date signed \_\_\_\_\_

**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 Van Lanson (Apprentice), Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed John B. Camp  
Licensed Embalmer No. 29515  
P. O. Address 14 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.**