

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 MAR 11 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

5383

608

Registration District No. 399

Primary Registration District No. 1002

Registrar's 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:  
6100 Indiana *7*  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 Days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Miss Margaret F. Duff

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

4. Sex Fe 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 Dec. 19 1872  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>1</u>	<u>18</u>	..... hr. .... min.

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

10. Usual occupation Home

11. Industry or business 4

12. Name Robt. F. Duff *9*

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Mrs. M. M. Crause

(b) Address 6100 Indiana Kansas City

17. (a) Burial (b) Date thereof Febr. 10 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Eylar Funeral Home

18. (a) Signature of funeral director M. M. Crause

(b) Address 1800 Linwood K.C. Mo.

19. (a) Feb. 9, 1940 (b) M. M. Crause  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 6100 Indiana  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2-7-40 day 7 year 1940 hour 8:00 minute 00 M.

21. I hereby certify that I attended the deceased from 8:00 a.m. to 10:00 a.m. 1940, to 10:00 1940; that I saw him alive on 2-7-40 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia

Due to 108

Due to .....

Other conditions 108  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations .....

Of autopsy .....

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? Yes (Specify type of place) 4

23. Signature M. M. Crause (M. D. or other) 4

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Chas Wickes

Licensed Embalmer No. 264x

P. O. Address 1500 Sunwood

**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.**