

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

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

5460

Registrar's No.

685

Registration District No.

Primary 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 3 Mo. & 12 days
 (Specify whether
 In this community 25 Yrs.
 years, months or days)

3. (a) PRINTED FULL NAME MARGARET BARRETT

3. (b) If veteran, name war No 3. (c) Social Security No. 496-09-6478

4. Sex Female 5. Color or race W 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. 1st, 1876
 (Month) (Day) (Year)

8. AGE:	Years <u>63</u>	Months <u>2</u>	Days <u>II</u>	If less than one day hr. <u>--</u> min.
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9. Birthplace Chapman Kansas
 (City, town, or county) (State or foreign country)

10. Usual occupation Waitress

11. Industry or business

12. Name Phillip Barrett
 18. Birthplace Ireland
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Slavens
 15. Birthplace Canada
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Emma Morgan
 (b) Address 904 East 11th.

17. (a) Removal (b) Date thereof 2/16/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Shapman Ave Has

18. (a) Signature of funeral director H.P. Mayberry

(b) Address 2315 Linwood Blvd.

19. (a) Feb. 15, 1940 (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. 2904 Prospect
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13th
 year 1940 hour 5 minute 35 A. M.

21. I hereby certify that I attended the deceased from 11-1-39, 19____, to 2-13-40, 19____;
 that I last saw her alive on 2-13-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Adenocarcinoma of colon with perforation of ileum.

Due to 46

Due to _____

Other conditions Bronchopneumonia
 (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 C.F.D. Maria M.D. (M. D. or other)
Supt. K.C. Gen. Hospital, K.C. Mo.
 Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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 MR

....., Registered Apprentice No.

working under my personal supervision.

Signed Ray E. Snow

Licensed Embalmer No. 25760

P. O. Address 1807 East 29th

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.