V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 9873

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1307

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

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 7003 Bellefontain Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 43 Yrs.
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 7003 Bellefontain Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Mrs. Fannie L. GUNN. 500

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife John W. Gunn.

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased December (Month) 14th, (Day) 1868. (Year)

8. AGE: Years 71 Months 3 Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name John Noland
13. Birthplace ..... (City, town, or county) Kentucky. (State or foreign country)

MOTHER
14. Maiden name Emma Cavanaugh.
15. Birthplace ..... (City, town, or county) Kentucky. (State or foreign country)

16. (a) Informant J. Frank Gunn.
(b) Address 7003 Bellefontaine Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Mellody-McGilley.
(b) Address K. C. Mo.

19. (a) Mch 25, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month ..... day 3-23-40
year ..... hour ..... minute 9 00 P.

21. I hereby certify that I attended the deceased from ..... , 19..., to ..... , 19...;
that I last saw him alive on ..... , 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Acute pulmonary edema

Due to Chronic diffuse myocardial fibrosis

Due to Coronary veterans 93c

Other conditions
(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? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature Victor M. Mahler (M. D. or other)
Address K. C. Mo. Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

## 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 _____

Licensed Embalmer No. 2799

P. O. Address _____

**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.**