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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13746

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1458

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: General Hospital No. 2. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3-15-40-4-1-40 (Specify whether years, months or days)

In this community 25 years

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.: 1214 Lydia (rear) (If rural, give location)

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

3. (a) PRINT FULL NAME: Alice Marshall 624

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: Negro

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

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: 3 (Month) 13 (Day) 1865 (Year)

8. AGE: Years 75 | Months 0 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace: Mo. 6 (City, town, or county) (State or foreign country)

10. Usual occupation: none 7

11. Industry or business: 7

FATHER
12. Name: Unknown 9
13. Birthplace: Unknown (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Record Clerk

(b) Address: General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-4-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Highland Cem.

18. (a) Signature of funeral director: Flynn & Greenstreet

(b) Address: April 3, 1940 City

19. (a) ____ (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 1 year 40 hour 3 minute 45 A. M.

21. I hereby certify that I attended the deceased from 3-15- 19 40 to 4-1- 19 40; that I last saw her alive on 4-1- 19 40 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive Type of Heart Disease.	
Due to:	
Due to:	
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: [illegible] (M. D. or other)

Address: General Hospital #2 Date signed: 4-1-40

(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 Edw. G. Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E N State Ma

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.