

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.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

14075

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1787

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:
2610 East 35th Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 35 years
 (Specify whether years, months or days)

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. 2610 East 35th Street
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Priscila Doty *3as*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased November 7 1886
 (Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 20 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Sterling Cooper

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

14. Maiden name Jane Leonard

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

16. (a) Informant's own signature M. S. Doty

(b) Address 2610 East 35th St.

17. (a) burial (b) Date thereof 4-29-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn - R.C.K.

18. (a) Signature of funeral director Doty Funeral Home

(b) Address Kansas City, Kansas

19. (a) April 28, 1940 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1940 hour 1 am

21. I hereby certify that I attended the deceased from May 10 1940 to May 10 1940 that I last saw her alive on April 27 1940 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis
Chalazystis
 Due to _____
 Due to _____

Duration 1 yr. 4 months

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations none
 Of autopsy _____
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature M. M. Crowe (M. D. or other) _____
 Address 2610 East 35th St. Date signed 4/27/40

V. A. Stapp
Argyle Bldg
2-11

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 D. Rose Blanford
Licensed Embalmer No. 4015
P. O. Address 1815 W. 41st

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.