

No. 2
-10-39
7-39
X21482

MAY 15 1940 399

1002

Registrar's No. 1808

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kaw

(c) Name of hospital or institution: Wesley Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days
(Specify whether)

In this community 25 Years
years, months or days)

3. (a) PRINT FULL NAME Dora Elizabeth Hutton 350

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Lem H. Hutton

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased July 15 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>9</u>	<u>11</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John M. Maulding

18. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth No Record

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Lem H. Hutton

(b) Address 145 North Bellaire

17. (a) Burial (b) Date thereof 4-29-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn, K.C. Mo

19. (a) April 29, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Missouri
(If outside city or town limit, write "RURAL")

(d) Street No. 145 North Bellaire
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from April 20
1940 to April 26 1940
that I last saw her alive on April 26 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Oedema of brain

Duration _____

Due to _____

Due to _____

Other conditions Emphysema of bladder!
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

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

While at work? no (Specify type of place)

(e) Means of injury no

23. Signature J. F. Mackey (M. D. or other) _____

Address Professional Bld Date signed 4-27-40

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

125

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 *Theron A. Redmon*

Licensed Embalmer No. *2787*

P. O. Address *H. C. Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 1808-

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Aura E. Hutton

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

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

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

19. MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr. Day 26 - Year 40
year..... hour..... minute..... M.

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

Immediate cause of death Edema of brain
Due to.....
Due to.....
1250

Other conditions Surgere of bladder
(Include pregnancy within 6 months of death)
Due to Cyphitis
Major findings:
Of operations.....

Of autopsy.....

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 J. J. Mackey (M.-D. or other)
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal)

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

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

(b) Address.....

19. (a) 4/29/0 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

S-14096