

No. 2  
1-10-34  
17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17620

State File No.

Registrar's No.

2147

Registration District No. 399

Primary Registration District No. 1002

I. 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  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
(Specify whether  
In this community 5 years  
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. Katy Hotel, 8th & Main  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22nd  
year 1940 hour 5 minute 50 P M.

21. I hereby certify that I attended the deceased from  
May 9th, 1940 to May 22nd 1940, 19\_\_\_\_;  
that I last saw him alive on May 22nd, 1940, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Carcinoma of bladder with gangrenous  
cystitis and purulent retroperiton-  
itis  
Due to 51

Due to \_\_\_\_\_  
Other conditions Terminal bronchopneumonia  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
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?  
3 (a)  
(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature R. F. De Munnis M.D. (M. D. or other)  
Supt. K. C. Gen. Hospital  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN WOOLSEY H 20

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

4. M sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife Katherine Woolsey 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Jan. 17th 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>4</u>	<u>5</u>	_____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph Woolsey

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

14. Maiden name Sabrina Nemstreet

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

16. (a) Informant Record clerk

(b) Address K. C. Gen. Ho spital, K. C. Mo.

17. (a) Burial (b) Date thereof 5 25 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Granalawn

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

(b) Address 2332 Monitor Place, K. C. Mo.

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

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

**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 *Blaine E. Walcutt*

Licensed Embalmer No. *4075*

P. O. Address *2332 Monitor Fla*

**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.**