

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17625**
Registrar's No. **2152**

Registration District No. **399**

Primary Registration District No. **1002**

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:
4300 East 24th. St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **35 Yrs.** years, months or days)

3. (a) PRINT FULL NAME **Elizabeth Donoho** **500**

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

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

6. (b) Name of husband ~~or wife~~ **George Donoho** 6. (c) Age of husband or wife if alive **86** years

7. Birth date of deceased **April 30th. 1854**
(Month) (Day) (Year)

8. AGE: Years **86** Months **0** Days **23** If less than one day
hr. _____ min. _____

9. Birthplace **Waretown N.J.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **At Home**

12. Name **Unknown**

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

14. Maiden name **Anna Goff**

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

16. (a) Informant **Mrs. Ramona Stark Ch. 0921**

(b) Address **4300 East 24th. St.**

17. (a) **Removal** (b) Date thereof **5/26/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Warrensburg Mo.**

18. (a) Signature of funeral director **W. Mayberry**
(b) Address **2315 Linwood Blvd**

19. (a) **May 26, 1940** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limit write "RURAL")
(d) Street No. **4300 East 24th. St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **24th.**
year **1940** hour **4** minute **P.M.** M.

21. I hereby certify that I attended the deceased from **May 4**, 19**40** to **May 24**, 19**40**
that I last saw her alive on **May 24**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Central thrombosis**
Duration **5/4/40**

Due to **Arteriosclerosis**

Due to **Senility** **87th**

Other conditions **Chronic Cholecystitis**
(Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

Duration

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?

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. Vincent** (M., D., or other)
Address **800 Ogden Bldg** Date signed **5/25**

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

MOTHER FATHER

Dr. Vincent
Argyle Blvd

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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, ~~by~~
....., Registered Apprentice No.
working under my personal supervision.

Signed: W.S. Mayberry
Licensed Embalmer No. 2934
P. O. Address 2315 Linwood Blvd.

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.