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

FILED JUL 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

20806

State File No.

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2423

1. PLACE OF DEATH:

(a) County Jackson 9

(b) City or town Kansas City 2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1017 Holmes Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community Unknown
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. 1017 Holmes Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Hazel Hall LARCOM 625

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife --

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

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

8. AGE: Years App. 70 | Months -- | Days -- | If less than one day hr. min.

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

10. Usual occupation Unemployed 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 J. H. Pryor
(b) Address K. C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/40 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director Mellody-McGilley
(b) Address K. C. Mo.

19. (a) June 13, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 11-40
year hour minute 6 P M.

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

Immediate cause of death Duration

Acute Pulmonary Edema

Due to Chronic Myocarditis

Due to

Other conditions 930
(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 5

23. Signature Russell W. (M. D. or other)
Address K. C. Date signed

(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 _____

Licensed Embalmer No. 2969

P. O. Address _____

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.