

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.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson County  
 (b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Little Sisters of the Poor  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution one year  
(Specify whether years, months or days)  
 In this community Unknown

3. (a) PRINT FULL NAME Mary Moore 6051

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

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

6. (b) Name of husband or wife William Moore 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Dec. 9 1865  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>6</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation None

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

12. Name Frank Kinney

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

14. Maiden name Grace Mallow

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

16. (a) Informant's own signature Sister Bernille Fay

(b) Address 5331 Highland Ave.

17. (a) Burial (b) Date thereof 7-28-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Quirk & Robin

(b) Address 20 W. Kenwood

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5331 Highland  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26  
 year 1940 hour 11 minute 45 A. M.

21. I hereby certify that I attended the deceased from July 1,  
1940, to July 23, 1940;  
 that I last saw him alive on July 23, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>76 hypertension Heart disease</u>	<u>year</u>
<u>cerebral thrombosis</u>	<u>2 week</u>
Due to <u>Generalized arteriosclerosis</u>	
Due to <u>750</u>	

Other conditions ---  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations none  
 Of autopsy none

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) no  
 (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 John T. Shuman (M. D. or other) MD  
 Address 1402 Bryant Bldg. Date signed 7-27-40

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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, or by.....

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

Signed.....

Licensed Embalmer No.....

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.