

Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(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: **None -- 4835 Brooklyn**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None** (Specify whether **2**)
In this community **40 Years.**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **4835 Brooklyn Avenue, K.C.Mo.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **31st**,
year **1940** hour _____ minute **9:05 P.M.**

21. I hereby certify that I attended the deceased from **July 31**, 19**40** to **July 31**, 19**40**
that I last saw **her** alive on **July 31**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Heart Smothering**
Due to **Controlled Asphyxia**
Due to **Smothering 9:20**

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULLNAME **Elizabeth Mayes, 907**
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 **Widow**
6. (b) Name of husband or wife **John Mayes** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept. 16th, 1859**
(Month) (Day) (Year)

8. AGE: Years **80** Months **10** Days **15** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housework**

11. Industry or business _____

MOTHER FATHER { 12. Name **Robert Thornberg,**
13. Birthplace **Ohio.**
(City, town, or county) (State or foreign country)
14. Maiden name **Clorinda Wright**
15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clinton T. Mayes,**
(b) Address **4835 Brooklyn Avenue, K.C.Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 3-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Forest Hill.**

18. (a) Signature of funeral director **Mrs. C. L. Forster**
(b) Address **918 Brooklyn Avenue, K.C.**

19. (a) **Aug. 2, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury **!**
23. Signature **Carl J. Brown** (M. D. or other) **Mo**
Address **1103 E. Brown** Date signed **8-1-40**

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

DEC 10 1941

Dr. Carl Jackson,
Douglas "

1103 E. Armona
Wes. 4193
about "

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 me

..... Registered Apprentice No.

working under my personal supervision.

Signed C. H. Wise

Licensed Embalmer No. 2570

P. O. Address H - C. Me

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, fact should be so stated above.