

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27540**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3173**

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:
3339 Charlotte Street, 2)
(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)

3. (a) PRINT FULL NAME Mrs. Ethel Herd 630

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

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

6. (b) Name of husband or wife William C. Herd, 8. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased October 26, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 9 13 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Morris

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

14. Maiden name Unknown

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

16. (a) Informant Sidney W. Reed,

(b) Address 3339 Charlotte St., Kansas City, MO.

17. (a) Cremation (b) Date thereof Aug. 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cremation

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Aug. 9, 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 limits write "RURAL")
(d) Street No. 3339 Charlotte Street,
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th,
year 1940 hour 7:30 minute A. M.

21. I hereby certify that I attended the deceased from
Jan 1 - 1938 to Aug 9th 1940
that I last saw her alive on Aug 8, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
with Angina Pectoris

Due to Coronary Stenosis 3 days
9/8

Due to _____
Other conditions Chronic Hypertension 3 yrs
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____

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 F. J. Jamar (M. D. or other) _____
Address 624 Ingemore Date signed Aug 9, 1940

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

