No. 2
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FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30949

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3512

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

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: 1913 Agnes (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether

In this community 10 yrs. years, months or days)

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. 1913 Agnes (If rural, give location)

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

3. (a) PRINT FULL NAME Mary Cain

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Wm J. Cain

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Aug (Month) 10 (Day) 1885 (Year)

8. AGE: Years 55 Months 0 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace Logan County Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Wm J Cain

(b) Address 1913 Agnes

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/40 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director [illegible]

(b) Address K C Mo

19. (a) Sept. 8, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day 9-4-40

year ..... hour ..... minute 6 a. M.

21. I hereby certify that I attended the deceased from Sept 7 Corona, 19..., to ..., 19...;

that I last saw ..... alive on ..., 19...;

and I hereby certify that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of left breast with metastasis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 50

Duration

PHYSICIAN 50

Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

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? (Specify type of place) 5

23. Signature [illegible] (M. D. or other)

Address K. C. Mo. 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. 3754

P. O. Address KMO

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.