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

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

31083

State File No. 3646

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

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:
122 N. Bellaire
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -- (Specify whether
In this community 36 years
years, months or days) Matthew F. McCune

3. (a) PRINT FULL NAME MATTHEW F. McCUNE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race W

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

6. (b) Name of husband or wife Edith McCune

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

7. Birth date of deceased March 3, 1857
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
83	6	14	hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country) 1

10. Usual occupation Carpenter 9

11. Industry or business --- 1

FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country) 1

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

16. (a) Informant Mrs. Edith McCune

(b) Address 122 N. Bellaire, K.C.Mo.

17. (a) ~~Xxxx~~ Removal (Burial, cremation, or removal) (b) Date thereof Sept. 18, 40 (Month) (Day) (Year)

(c) Place: burial or cremation Council Bluffs, Iowa

18. (a) Signature of funeral director C.H.Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd. K.C.Mo.

19. (a) Sept. 18, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

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. 122 N. Bellaire
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 9-17-40
year hour minute M.

21. I hereby certify that I attended the deceased from 10:15 A.
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Acute pulmonary edema

Due to Hemorrhage into atheromatous

Due to abscess & coronary occlusion

Other conditions
(Include pregnancy within 3 months of death)
Coronary sclerosis 94B

Major findings:
Of operations
Of autopsy Yes

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 (Specify type of injury)

23. Signature [signature] (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 H D Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.