S. No. 2
—11-10-39
r. 5-17-39
1 X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 34379

Registrar's No. 3895

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: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks (Specify whether
In this community 3 Weeks years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Clinton Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Clinton Mo.
(If rural, give location)

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

3. (a) PRINT FULL NAME Betty N. Stevens

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Fe.

5. Color or race Wh.

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

6. (b) Name of husband or wife Wm. M. Stevens

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

7. Birth date of deceased June (Month) 16 (Day) 1864 (Year)

8. AGE: Years 76 | Months 3 | Days 22 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Home

11. Industry or business

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

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

16. (a) Informant Consalus Undertaker

(b) Address Clinton Mo.

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

(c) Place: burial or cremation Clinton Mo.

18. (a) Signature of funeral director Consalus & Peck

(b) Address Clinton Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8-7 year 1940 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from Sept 20, 1940, to Oct 7, 1940; that I last saw her alive on Oct 7, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis, Acute Pulmonary Congestion

Due to age 135 a

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations Suprafabric Cystotomy
Of autopsy 9/29/40

Duration

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? (e) Means of injury

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

Address 505 Professional Bldg Kansas City Mo Date signed 9/8/40

(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 Chas Wilks

Licensed Embalmer No. 2644

P. O. Address 1800 Linwood

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.

S. No. 2B
—2-21-40
1 X22659

ROWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34374

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3895

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: K. C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Betty N. Stevens
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced .....
6. (b) Name of husband or wife .....
6. (c) Age of husband, or wife, if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)
8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER 12. Name .....
FATHER 13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER 14. Maiden name .....
MOTHER 15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) 10/8/41 (Date received by local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7-1940 year ..... hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 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: Acute Myocarditis — *Duration*
Due to: Pulmonary congestion
Due to: .....
Other conditions (Include pregnancy within 3 months of death): NO
Major findings: Of operation: Supra pubic cyst — tot. removal — 9-24-40
Of autopsy: Chronic cystitis no malignancy

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? .....
While at work? ..... (Specify type of place) (e) Means of injury .....
23. Signature: Gustav Zeuch (M. D. or other)
Address ..... Date signed .....

SUPPLEMENTARY