. No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34431

FILED NOV 12 1940

Registration District No. 3940

Primary Registration District No. 1002

Registrar's No. 3947

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: 619 E. 8th St., K.C.Mo. 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 57 years
years, months or days)

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")

0

(d) Street No. 619 E. 9h st.
(If rural, give location)

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

3. (a) PRINT FULL NAME Minna Ellen David

3. (b) If veteran, name war xxxxxxx

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife W.J.David

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased June 21st 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 21 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Housewife 1

11. Industry or business None 1

FATHER
12. Name George Long
13. Birthplace Madison (City, town, or county) Kansas (State or foreign country)

MOTHER
14. Maiden name Margaret Long
15. Birthplace Madison (City, town, or county) Kansas (State or foreign country)

16. (a) Informant H.J.Davis

(b) Address 619 East 8th St., K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-1940 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Mt. Hope Cemetery, K.C.Ks.

(b) Address Sheil Funer Home, 6606 Indep. Ave. K.C.Mo.

19. (a) 10-14-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12th year 1940 hour 7 minute 15 A. M.

21. I hereby certify that I attended the deceased from 2-17-40, 19__, to 10-12-40, 19__; that I last saw her alive on October 10th 1940, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Carcinoma of cervix with extensive

Due to metastases to rectum, bladder, etc.

Due to 48

Other conditions Generalized peritonitis.
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None 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? (e) Means of injury 1

23. Signature Drury R. Thorn (M. D. or other)

Address Med. Dir. K.C. Gen. Hosp. K.C.Mo. Date signed 10-13-40

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

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