No. 2
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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. 37632

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4230

FILED DEC 11 1940

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: K.C.General Hospital No. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community Life

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. 1604 Skiles (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME MARYBELLE HAWORTH
3. (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 Bert Hawarth
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased March (Month) 11 (Day) 1885 (Year)

8. AGE: Years	Months	Days	If less than one day
55	7	24	hr. ____ min.

9. Birthplace Lamina (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Housewife 1
11. Industry or business 1
FATHER 12. Name James Goodman
FATHER 13. Birthplace (City, town, or county) Indiana (State or foreign country)
MOTHER 14. Maiden name Libby Kuloria
MOTHER 15. Birthplace (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Merida L. Haworth
(b) Address 1034 W VanHorn
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Washington
18. (a) Signature of funeral director Ott & Mitchell
(b) Address Independence, Missouri
19. (a) 11-6-40 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5th year 1940 hour 9 minute 45 P. M.
21. I hereby certify that I attended the deceased from Oct. 29th, 1940 to Nov. 5th, 1940; that I last saw her alive on Nov. 5th, 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death MALIGNANT BRAIN TUMOR — Duration
Due to 53
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy See above

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 Irving R. Stone (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed 11-6-40

(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. 64 6

P. O. Address 910 N. Main St

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

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