

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37892
Registrar's No. 4490

Registration District No. 399

Registration District No. 1002

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED DEC 17 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: General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-12-40-11-22-40
(Specify whether years, months or days) 9 Years

3. (a) PRINT FULL NAME Wynne Monroe

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Oct. 1 24
(Month) (Day) (Year)

8. AGE: Years 16 Months 1 Days 21 If less than one day hr. min.

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

10. Usual occupation Student

11. Industry or business

MOTHER FATHER { 12. Name William Monroe

18. Birthplace Kans.
(City, town, or county) (State or foreign country)

14. Maiden name Willa Shaw

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

16. (a) Informant's own signature Record Clerk
(b) Address Gen. Hosp. #2

17. (a) burial (b) Date thereof 11-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highlands

18. (a) Signature of funeral director
(b) Address 1729 Lydia

19. (a) 11-25-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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")
Street No. 3005 E. 54th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 22
year 40 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from 10-12-40, 1940, to 11-22, 1940

that I last saw him alive on 11-22-40, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death. Acute pulmonary edema as a result of insulin shock therapy

Due to Schizophrenia

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

While at work? (Specify type of place) Means of injury

23. Signature (M.D. or other)
Address Gen. Hosp. #2 Date signed 11-25-40

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.....

Isaac Jerome Manley

Licensed Embalmer No. *3994*

P. O. Address *1120 E. 23rd St*

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.