

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37930
Registrar's No. 4528

Registration District No. 399

Primary Registration District No. 1002

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:
2030 Benton Blvd
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
(Specify whether years, months or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2030 Benton Blvd
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME ADA BELLE McCLINTICK

8. (b) If veteran, name war no (c) Social Security No. 496-01-3946

4. Sex Female 5. Color or race wh.
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Ray Mc Clintick 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 6 - 1 - 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 5 24 hr. min.

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

10. Usual occupation Cashier

11. Industry or business Alladin Theatre

MOTHER FATHER
12. Name John Carter
13. Birthplace Mo
14. Maiden name Barbara Mc Reynolds
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature H. H. Parsons

(b) Address 2030 Benton Blvd

17. (a) Burial (b) Date thereof 11-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Joplin Mo

18. (a) Signature of funeral director John P. Shield

(b) Address 6606 Independence

19. (a) NOV. 27, 1940 (b) M. H. Croome
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 25th
year 1940 hour 4.05 minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 19,
1940, to Nov. 25, 1940
that I last saw her alive on Nov. 25, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death failure of respiratory center
Due to cerebral hemorrhage Duration minutes
Due to 820

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 2

23. Signature Herman Skablan (M. D. or other) Q.C.
Address 3208 Maple Ave. Date signed 11-26-40

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.

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.....

Joe B. Yoder....., Registered Apprentice No. *# 233*
working under my personal supervision.

Signed.....*John P. Phil*
Licensed Embalmer No. *3625*
P. O. Address.....*K. C. Mo.*

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.