

JAN 8 1941

Registration District No. **399**Primary Registration District No. **1002**Registrar's No. **4632**

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:
St. Joseph Hospital,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **16 days.**
(Specify whether years, months or days)

In this community **1 week.**

3. (a) PRINT FULL NAME **Max A. Derryberry.**

3. (b) If veteran, name war. **No.**

3. (c) Social Security No. **522-07-0951**

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Grace N. Derryberry,**

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

7. Birth date of deceased **October 5th 1893**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

47 2 0 hr. min.

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

10. Usual occupation **Insurance Manager,**

11. Industry or business **Insurance,**

MOTHER FATHER { 12. Name **Charles H. Derryberry,**

13. Birthplace **Tennessee,**

14. Maiden name **Alice E. Thatcher,**

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

16. (a) Informant **Mrs. Grace N. Derryberry,**

(b) Address **St. Joseph, Mo.**

17. (a) **Removal,** (b) Date thereof **12-5-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Denver, Colorado**

18. (c) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Hillham Plaza, K. C., Mo.**

19. (a) **12-5-40** (b) **M. M. Browe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri,** (b) County

(c) City or town **St. Joseph,**
(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.? **NO.** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **5th**
year **1940,** hour **12:10** minute **A.** M.

21. I hereby certify that I attended the deceased from **July 13**
1940 to **December 5,** 1940;
that I last saw him alive on **Dec. 4,** 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death **Brain Tumor**
"Right frontal spongioblastoma"

Due to **54 P**

Other conditions
(Include pregnancy within 3 months of death)

Major findings: **Brain Tumor.**

Of operations **None done**

Of autopsy **None done**

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 **J. A. Carmichael Jr.** (M. D. or other)

Address Date signed

Dr. Carmichael, No. 1145-

1-4

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 E. M. Plouffe

Licensed Embalmer No. 1848

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, fact should be so stated above.