

No. 2  
13-40  
17-39  
X23159

FILED FEB 19 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1397  
357  
Registrar's No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

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 2042 BRIGHTON  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 Years  
(Specify whether years, months or days)

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. 2042 Brighton  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME MATTIE M MOYERS

MEDICAL CERTIFICATION

3. (b) If veteran, name war No 3. (c) Social Security No. None

20. DATE OF DEATH: Month Jan. day 23 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Fe. 5. Color or race Wh. John 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased June 6 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 2 - 1941 to Jan 22 - 1941  
that I last saw her alive on Jan 22 - 1941 and that death occurred on the date and hour stated above.

Immediate cause of death acute cardiac failure Duration 6 hrs.

8. AGE 77 Years 9 Months 17 Days If less than one day hr. \_\_\_\_\_ min.

Due to bronchial (bleb) pneumonia 11 da.

9. Birthplace Unknown Ken. /  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

10. Usual occupation housewife

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business W

PHYSICIAN

MOTHER FATHER { 12. Name Wm. Pollock  
13. Birthplace Unknown Ken. /  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Daws  
15. Birthplace Unknown Ken. /  
(City, town, or county) (State or foreign country)

Major findings: Of operations   
Of autopsy   
Underline the cause to which death should be charged statistically.

16. (a) Informant J. R. Moyers  
(b) Address 137 N. Lawndale

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof Jan. 25, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn

(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?

18. (a) Signature of funeral director Rose & Henderson  
(b) Address 15 & Jackson

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

19. (a) Jan 24 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

23. Signature Chas. Surber (M. D. or other)  
Address 636 Orange Bldg. KC Mo. Date signed 1-24-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Switzger  
Argyle, N.Y.

**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.....

working under my personal supervision.

Registered Apprentice No. ....

Signed.....

*[Handwritten Signature]*  
E. Henderson

Licensed Embalmer No. *3657*

P. O. Address *A. B. 2nd*

**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.**