

No. 2
1-10-39
-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5878**

ISSUED MAR 14 1941

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **650**

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:
1723 Charlotte
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 30 years
years, months or days)

3. (a) PRINT FULL NAME Mallie Sterenson
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex 7
 5. Color or race Cobred
 6. (a) Single, widowed, married, divorced 3
 6. (c) Age of husband or wife if alive deceased years
 7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Unknown

11. Industry or business _____

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Pearl Fisher
 (b) Address 5406 South Benton

17. (a) burial (b) Date thereof 2/13/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

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

19. (a) 2/13/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
Kansas City
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. 1723 Charlotte
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 15
 year 1941 hour 9 minute _____ A. M.

21. I hereby certify that I attended the deceased from Feb 9
 _____, 1941, to Feb 10, 1941;

that I last saw her alive on Feb 9, 1941;

and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Infarct

Due to _____

Due to _____

Other conditions Rheumatism
(Include pregnancy within 3 months of death)

Major findings:
 Of operations none

Of autopsy none

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) (e) Means of injury

While at work? _____

23. Signature J. Guggenheimer, M.D. (M. D. or other)
 Address 2202 E 78 Date signed 2/12/41

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

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

B. L. Graham

Licensed Embalmer No.

2540

P. O. Address

2208 Vine 2

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.