

No. 2
-1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9529

State File No. _____

APR 15 1941

Registrar's No. 938

Registration District No. _____

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 or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2-28-41-2-28-41
(Specify whether years, months or days) 84 years

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. 1712 Michigan Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Maggie Moppins

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

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

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

7. Birth date of deceased 2 ' 15 1857
(Month) (Day) (Year)

8. AGE: Years 84 Months 1 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Owens

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

14. Maiden name Frances Montgomery

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

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) burial (b) Date thereof 3/6/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Haskins Bros.
1729 Lydia

(b) Address _____
19. (a) 3/6/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 28
year 41 hour 11 minute 25 P. M.

21. I hereby certify that I attended the deceased from 2-28- 19.41 to 2-28- 19.41
that I last saw her alive on 2-28- 19.41
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
Due to Acute Cardiac Failure

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) (e) Means of injury _____

23. Signature P. O. ... (M. D. or other) _____
Address Hosp. #2 Date signed 3-3-41

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

18
3
8

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 Monlon*
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, fact should be so stated above.