

No. 2
-1-4-41
5-17-39
I X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13333
State File No. _____
Registrar's No. **1314**

Registration District No. 397
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 3-6-41-3-23-41
(Specify whether years, months or days) 35 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. 1112 E. 14th St., 3rd Fl. W.C.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Matilda Quarles

3. (b) If veteran, name war no
3. (c) Social Security No. Don't know

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

6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb unk 1846
(Month) (Day) (Year)

8. AGE: Years about 95 Months 1 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Sallie Hicock
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 4-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge

18. (a) Signature of funeral director Philip M. [unclear]
(b) Address City

19. (a) Apr 3 1941 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 23
year 41 hour 6 minute 05 A.M.

21. I hereby certify that I attended the deceased from 3-6- 1941 to 3-23- 1941
that I last saw her alive on 3-23- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to Fractured Femur

Due to Prob. Carcinoma of Left Breast

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

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) as 123
(b) Date of occurrence Unknown - Receipt
(c) Where did injury occur? K. B. Jackson Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

While at work? _____ (Specify type of place)
(e) Means of Injury Fall

23. Signature [Signature] (M. D. or other) 0
Address Essex St. opp. #2 Date signed 3-25-41

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

18
3
8

48
3
6
0

Duration
56
10
15
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Edw. Stevens
3-28-41
Licensed Embalmer No. 3836
P. O. Address 1819 E 15th 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.