

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

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:  
4217 Dearitt Ave. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No  
(Specify whether)

In this community 48 yrs.  
years, months or days

3. (a) PRINT FULL NAME Jenny E. Whaley

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race Wh.

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

6. (b) Name of husband or wife Frank H. Whaley

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased 11-18-1892  
(Month) (Day) (Year)

8. AGE: Years 48 Months 4 Days 23 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name James W. Gordon

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

14. Maiden name Catherine O'Leary

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

16. (a) Informant Frank H. Whaley

(b) Address 4217 Dearitt

17. (a) Burial (b) Date thereof 4-14-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director John P. Hill

(b) Address Kansas City Mo.

19. (a) Apr 13 1941 (b) M. M. Crown  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1466

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 4217 Dearitt Ave 8  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? No 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from March - 18  
\_\_\_\_\_, 1941, to April - 11, 1941;  
that I last saw her alive on April - 11, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction 3 days

Due to Carcinoma stomach and liver 1 yr. 7  
(30 days to my knowledge) ✓

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 S. S. Hubbard (M. D. or other) \_\_\_\_\_  
Address 226 East 13th St Date signed 4-13-41

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

18  
3  
8

46

EMBA

**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

*Samuel Sheel*

Licensed Embalmer No. *8625*

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13485  
Registrar's No. 1466

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

OWENA MOORE

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4217 Scarritt Avenue  
(If not in hospital or institution, write street number or location)

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

In this community.....

3. (a) PRINT FULL NAME Jenny E. Whaley

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>4</u>	<u>23</u>	hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) 4/13/41 (b) (Registrar's signature) M. J. Crowe

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (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.?..... years.

20. DATE OF DEATH Month April day 4<sup>th</sup> year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction Duration.....

Due to Peritonitis stomach & liver

Due to Primary lesion in stomach (234)

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

Major findings:  
Of operations.....  
Of autopsy.....

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) While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other) Address..... Date signed.....

