

No. 2  
4-13-40  
5-17-39  
I X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13557  
1538  
Registrar's No. \_\_\_\_\_

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

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

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:  
2506 East 29th Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 1 Year  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Mary Jane Koontz  
(b) If veteran, name No  
(c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Mr. William H. Koontz 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased February 28 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77 1 18 hr. min.

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

10. Usual occupation Milliner

11. Industry or business Retired

MOTHER FATHER { 12. Name Allen Collie  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Gifford  
15. Birthplace Unknown Ohio 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Edith Wilson  
(b) Address 2506 E 29th St

17. (a) Cremation (b) Date thereof Apr. 18, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place, by or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer's Sons  
(b) Address 1401 Brush Creek Blvd.

19. (a) Apr 17 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2506 East 29th Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 7 day 16th  
year 1941 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from April 1st  
1941, to April 12, 1941;  
that I last saw her alive on April 12, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
+ Bilateral Pneumonia  
Duration 5 days  
7 days

Due to \_\_\_\_\_  
Due to gzw  
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 Shelley H. Graham (M. D. or other) M.D.  
Address 518 Argyle Bldg. Date signed 4-17-41

518 Wiggins Ave  
1:30 PM

**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.....

*Carole M. Colborn*

Licensed Embalmer No. 3506

P. O. Address K C Ms

**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. ....

Registrar's No. 1538

Registration District No. ....

Primary Registration District No. ....

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(c) Name of hospital or institution: 2506 East 29th Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Mrs Mary Jane Koontz  
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  
77 .....

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

10. Usual occupation.....

11. Industry or business.....

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) ..... (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) 9/12/41 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

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.

DECLARATION OF MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th  
year 1941 hour..... minute..... M.

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

Immediate cause of death: Cerebral Hemorrhage Duration 3 days  
Bilateral pneumonia (Bleeds) 7 .....

Due to.....

Due to.....

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 A. H. Graham (M. D. or other) M.D.

Address 518 Argyle Bldg Date signed 5-21-41

SUPPLEMENTAL

S-13557