No. 2
-1-4-41
5-17-39
I X263

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24348

10 1941

District No. 399 Primary Registration District No. 1002 Registrar's No. 2887

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: K.C. General Hospital No. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days) In this community —— 0

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 048
(c) City or town: Kansas City (If outside city or town limits, write "RURAL") 3
(d) Street No.: 1205 East 31st St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country: D

3. (a) PRINT FULL NAME: ALICE MARIE DANIELS
3. (b) If veteran, name war: ——
3. (c) Social Security No.: ——
4. Sex: Female
5. Color or race: W
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: ——
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Oct 25 (Month) 1931 (Year)
8. AGE: Years 9 Months 9 Days 4 If less than one day hr. min.
9. Birthplace: Cherryvale (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Student
11. Industry or business:
FATHER 12. Name: Lex G Daniel
FATHER 13. Birthplace: Arkansas (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Ina Wurford
MOTHER 15. Birthplace: Morton (City, town, or county) Kansas (State or foreign country)
16. (a) Informant: Mrs Lex G Daniel
(b) Address: 1205 E 31
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Floral Hills
18. (a) Signature of funeral director: Quirk & Tobin
(b) Address:
19. (a) 7-31-41 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29th year 1941 hour 10 minute 15 A. M.
21. I hereby certify that I attended the deceased from 7-27-41, 19.. to 7-29-41, 19.. ; that I last saw her alive on 7-29-41, 19.. ; and that death occurred on the date and hour stated above.

Immediate cause of death: Malignant tumor of Brain-type not determined pending further laboratory
Due to: investigation
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy: See above

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Henry R. Shaw (M. D. or other) D
Address: Med. Dir. K.C. Gen. Hospital Date signed:

361 (Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24348

Registration District No. 399 Primary Registration District No. 100 Registrar's No. 2887

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: K.C. General Hosp. No
(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 .....

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) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Alice M Daniels
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: f
5. Color or race: W
6. (a) Single, widowed, married, divorced: f
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 ..... 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: City
19. (a) 9/11/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 19
year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)
(b) 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 .....

SUPPLEMENTARY