

FILED SEP 12 1941

Registration District No. 299

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:  
St. Joseph Hospital,  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 days,  
(Specify whether  
In this community 15 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson,  
(c) City or town Kansas City,  
(If outside city or town limits, write "RURAL.")  
(d) Street No. 418 West 10th Street,  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Miss Venita Word,

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

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

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

7. Birth date of deceased February 24 1901  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
40 5 29 hr. min.

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

10. Usual occupation Accounting Clerk,

11. Industry or business X

MOTHER FATHER { 12. Name Albert Word,  
13. Birthplace Missouri, (City, town or county) (State or foreign country)  
14. Maiden name Cora Saunders,  
15. Birthplace Missouri, (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hazel Swearingen,

(b) Address Plattsburg, Mo.

17. (a) Removal, (b) Date thereof 8-25-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plattsburg, Mo.,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8/25/41 (b) M. H. Crowe  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd,  
year 1941 hour 10:15 minute P. M.

21. I hereby certify that I attended the deceased from 8-10-41 19, to 8-22-41 19, that I last saw him alive on 8-22-41 19, and that death occurred on the date and hour stated above.

Immediate cause of death.

Respiratory Paralysis

Due to Cerebellar Tumor (Malignant)

Other conditions (Include pregnancy within 3 months of death) F4B

Major findings: Neurologist - Brain Tumor

Of operations above

Of autopsy above

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 Specialist (M. D. or other) 0  
Address KC Mo Date signed \_\_\_\_\_

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

18  
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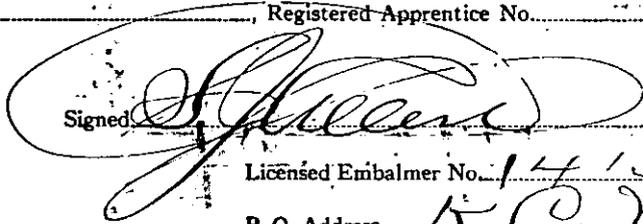
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**STATEMENT BY LICENSED EMBALMER**

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. 1413

P. O. Address K. O. M. C.

**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, above space should be left blank.**