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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27568

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3226

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: 622 Benton (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 20 Years / years, months or days)

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")
(d) Street No. 608 Cedar (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country C

3. (a) PRINT FULL NAME Annie Healy
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Fe 1
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John Healy
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Sept 5 (Month) 1876 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
64	11	21	..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Home
11. Industry or business .....
FATHER
12. Name Wm. Bufford
13. Birthplace ..... (City, town, or county) Ky. 1 (State or foreign country)
MOTHER
14. Maiden name Nancy Wilhite
15. Birthplace ..... (City, town, or county) ~~No record~~ Ky 1 (State or foreign country)
16. (a) Informant Harry L. Healy
(b) Address 608 Cedar
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation Mt Washington
18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918 Brooklyn K. C. Mo.
19. (a) 8/27/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26 1941
year 1941 hour 7 minute 30 a M.
21. I hereby certify that I attended the deceased from Mar 1 1941, to 8-26 1941;
that I last saw her alive on 8-21 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Mediastinal tumor with metastasis to chest Hypertension & Chronic
Due to Myocarditis
Due to 477
Other conditions (Include pregnancy within 3 months of death) 477
Major findings:
Of operations .....
Of autopsy .....

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 [signature] (M. D. or other) MD
Address 10307 Indep. ave. Date signed 8-26-41

(Licensed Embalmer's Statement on Reverse Side) K. C. Mo.

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. Clair Shipman

Licensed Embalmer No. 4179

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
I X29288

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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:
(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 Annie Healy

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 Wd

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 8/27/41 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 26 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)

(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY