

No. 2
1-4-41
17-39
X25390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30751

State File No.

Registrar's No. 3508

Filed OCT 13 1941 399
Registration District No.

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson
(a) County: Kansas City
(b) City or town: Kansas City
(c) Name of hospital or institution: Union Station 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Non-Resident
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: MAUD L. FROST
3. (b) If veteran, name war: No
3. (c) Social Security No.: No

4. Sex: Female
5. Race: White
6. (a) Single, widowed, divorced, or married: widow

6. (b) Name of husband or wife: Amos M. Frost
6. (c) Age of husband or wife if alive: 1872 years
7. Birth date of deceased: January 12 (Month) (Day) (Year)

8. AGE: Years 69, Months 8, Days 5
If less than one day hr. min.

9. Birthplace: Indiana (State or foreign country)
Housewife

10. Usual occupation:

11. Industry or business:

MOTHER FATHER {
12. Name: Unk. Bailey
13. Birthplace: Indiana (State or foreign country)
14. Maiden name: Don't know
15. Birthplace: Indiana (State or foreign country)

16. (a) Informant: Webb Funeral Home
(b) Address: Blue Springs, MO.

17. (a) Removal (Burial, cremation, or removal)
(b) Date thereof: Sept 21-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Blue Springs, Mo.
J.F. O'DONNELL CO

18. (a) Signature of funeral director: [Signature]
(b) Address: 3256 Broadway Kansas City Mo.

19. (a) Date received local registrar: 9/21/41
(b) Registrar's signature: M. M. Brown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 59
(c) City or town: Chillicothe Missouri (If outside city or town limits, write "RURAL")
1121 N. Walnut 2
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 9-20-41, year: 1941, hour: 11:40 A.M., minute: 11:40 A.M.

21. I hereby certify that I attended the deceased from [Signature] 19[] 19[]
that I last saw the deceased alive on [Signature] 19[] 19[]
and that death occurred on the date and hour stated above.

Immediate cause of death: Hemiplegia
Due to: [Signature]
Other conditions: [Signature]
(Include pregnancy within 3 months of death)

Major findings: Of operations: 96
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) 3
Address: [Signature] Date signed:

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.....

Park G. Rowe

Licensed Embalmer No.

2347

P. O. Address

N. C. Mo.

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.