

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33962
Registrar's No. 3902

Registration District No. 399

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: Lakeside Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 Days
In this community 21 Years (Specify whether 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. 541 Hardy Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18th
year 1941 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from Sept 28th 1941
to Oct. 18th 1941
that I last saw him alive on Oct 18th 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Intercerebral Hemiplegia et Myocardial Failure
Due to Arteriosclerosis et Cerebrovascular et Sympatric Stenosis
Due to Cerebral cyst twisted on pedicle.
Other conditions: Mental Instability due to shock from pain
Duration 2 Wks
9-24 to 9-28

Major findings: Cerebral Cyst - Stenoplastic pedicle from Sept 24 to 28th
Of operations: -----
Of autopsy: 560
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) (b) Means of injury -----
23. Signature W. C. Williams (M. D. or other) -----
Address 612 Chambers Bldg Date signed 10-18-41

3. (a) PRINT FULL NAME Barr Mrs. Dessie Maria Ainsworth

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

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

6. (b) Name of husband or wife Mr. Arthur Ainsworth 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased: August 14 1904
(Month) (Day) (Year)

8. AGE: Years 37 Months 2 Days 4 If less than one day ----- hr. ----- min.

9. Birthplace Mary's County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name John Abraham Barr

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

14. Maiden name Nora Alice Martin

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

16. (a) Informant Mr. Arthur Ainsworth

(b) Address 541 Hardy Avenue

17. (a) Burial (b) Date thereof Oct. 21, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director W. H. Newcomer

(b) Address 1401 Brush Creek Blvd.

19. (a) 10/20/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

19.C. no.

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

48
3
8

NOV 13 1941

12:30-5:30

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 *H.C. Newcomer*
Licensed Embalmer No. *4043*
P. O. Address *R.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.