

0. 2  
13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34080  
Registrar's No. 4020

Registration District No. 799

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: 5015 Thompson  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 44 Years (Specify whether years, months or days) /

3. (a) PRINT FULL NAME Ada C. Magee

3. (b) If veteran, name war No

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Richard S. Magee 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Aug 9, 1878  
(Month) (Day) (Year)

8. AGE: Years 63 Months 2 Days 19 If less than one day hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business House wife

12. Name William Eagles

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

14. Maiden name Emily R. Haley

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

16. (a) Informant Richard Magee

(b) Address 5015 Thompson

17. (a) Burial (b) Date thereof Oct 30, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood Cem

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918 Brooklyn

19. Oct 28, 1941 (Date received local registrar) (b) M M Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 5015 Thompson  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct - day 28 year 1941, hour 7 minute 15A M.

21. I hereby certify that I attended the deceased from June 1939, 1939, to Oct 28, 1941.  
that I last saw her alive on Oct 28, 1941, 1941, and that death occurred on the 28 and hour stated above.

Immediate cause of death: Coronary occlusion 30 Min

Due to Hypertension

Due to Nephritis

Other conditions: Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings: No

Of operations \_\_\_\_\_

Of autopsy No

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 No

(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 B Corbett MD (If Other) 0  
Address 715 Angelle Blvd R. PMO 19-28-41

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

238

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

Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address H. C. me

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4020

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

1. PLACE OF DEATH:

(a) County .....  
(b) City or town .....  
(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  
In this community .....  
years, months or days)

3. (a) PRINT FULL NAME. Ada C. Magee

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

4. Sex ..... 5. Color or race ..... 6. (a) Single, widowed, married, divorced .....  
6. (b) Name of husband or wife ..... 6. (c) Age of husband, or wife, if alive ..... year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
h. min.

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

10. Usual occupation.....

11. Industry or business.....

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) ..... (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10/28/41 (b) H. H. Crow (Dates received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.? ..... years.

20. DATE OF DEATH. Month October day 28  
year 1941 hour ..... minute ..... M.

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

Immediate cause of death  
Coronary occlusion

Due to Hypertension

Due to Nephritis Chronic

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

Major findings: Of operations. No

Of autopsy. No

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) (c) Means of injury.....

23. Signature M. P. Caselot M.D. (M.D. or other)

Address 713 Myrtle Bldg K.C. Mo.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

34080