. No. 2
—1-4-41
5-17-39
PI X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 22 1941

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 37483

Registrar's No. 4278

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1115 Forest Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 65 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1115 Forest Ave.
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Gertrude Sharp CUMMINS.

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife W. W. Cummins

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased August (Month) 17th, (Day) 1876 (Year)

8. AGE: Years	Months	Days	If less than one day
65	3	00	hr. min.

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

10. Usual occupation House Wife.

11. Industry or business .....

FATHER
12. Name Fenton Skinner
13. Birthplace ..... (City, town, or county) Pennsylvania (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Hagertown (City, town, or county) Maryland. (State or foreign country)

16. (a) Informant W. W. Cummins
(b) Address 1115 Forest Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/41 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill.

18. (a) Signature of funeral director Mellody-McGilley.
(b) Address K. C. Mo.

19. (a) 11-18-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17-41
year ..... hour ..... minute 4 [illegible]

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

Immediate cause of death Coronary Occlusion

Due to Duplicate Coronary Atherosclerosis

Due to Hemorrhage

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

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 [illegible] (Dr. or other)
Address [illegible] Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

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. 2999

P. O. Address.....

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.