

DEC 22 1941

Registration District No. 397

Primary Registration District No. 1002

Registrar's No. 4354

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:
3007 Jackson Avenue
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community 10 Years
 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. 3007 Jackson Avenue
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mrs. Florence Maud May

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 Widowed

6. (b) Name of husband or wife Mr. Floyd May 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 12 1897
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>5</u>	<u>10</u>	_____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name John Laughlin
 13. Birthplace Quincy Illinois
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Elizabeth Dollison
 15. Birthplace Agency Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edwin May
 (b) Address 3007 Jackson

17. (a) Burial (b) Date thereof Nov. 24, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 11111 Mt. Washington Cem.

18. (a) Signature of funeral director D. V. Newcome's Sons
 (b) Address 1401 Brush Creek Blvd.

19. (a) 11-24-41 (b) M. M. Crow
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22nd
 year 1941 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Oct. 15 - 1941 to Nov. 22, 1941
 that I last saw her alive on Nov. 14, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer internal & external Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy NO

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) NO
 (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 J. T. George (M. D. or other) _____
 Address 2408 Cleveland Bldg. Bldg. Date signed 11-22-41

PHYSICIAN

Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

2099
194
EMBALMER

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

W. Hervey Quisenberry

Licensed Embalmer No.

4070
W. C. Mo.

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 4354

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:
3007 Jackson 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
years, months or days)

3. (a) PRINT FULL NAME Mrs. Florence Maud May

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

8. AGE: Years 44 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

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 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 11/24/41 (b) Mr. M. Brown (Date 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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22nd
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.

Immediate cause of death

Cancer internal and external - Primary

Due to
552

Due to
552

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. Jimmy George

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

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

MOTHER FATHER

S-37559

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.....

..... 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.