S. No. 2
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v.
1-X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 16 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42018

Registration District No. 398 — Primary Registration District No. 5554 — Registrar's No. 345

48 0 0

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

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: U. S. Highway 40 and Blue Ridge Cutoff (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: x (Specify whether years, months or days) In this community: 34 years,

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri, (b) County: Jackson, 48
(c) City or town: Kansas City, 0 (If outside city or town limits, write "RURAL") 0
(d) Street No.: U. S. Highway 40 and Blue Ridge Cutoff (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: MARY WALLINGFORD
3. (b) If veteran, name war: x
3. (c) Social Security No.: x
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Eldon Wallingford,
6. (c) Age of husband or wife if alive: 56 years
7. Birth date of deceased: December (Month) 28 (Day) 1886 (Year)

8. AGE: Years	Months	Days	If less than one day
54	11	27	hr. min.

9. Birthplace: Missouri, (City, town, or county) (State or foreign country)
10. Usual occupation: Owner
11. Industry or business: Cross Country Inn
MOTHER FATHER
12. Name: John C. Reed,
13. Birthplace: Missouri, (City, town, or county) (State or foreign country)
14. Maiden name: Mattie Stiff,
15. Birthplace: Virginia, (City, town, or county) (State or foreign country)
16. (a) Informant: Eldon Wallingford,
(b) Address: 40 Highway & Blue Ridge Cutoff, K. C. Mo.
17. (a) Burial, (Burial, cremation, or removal) (b) Date thereof 12-29-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill Cemetery,
18. (a) Signature of funeral director: Stine & McClure,
(b) Address: 3235 Gillham Plaza, K. C., Mo.
19. (a) Dec. 29 41 (Date received local registrar) (b) F. L. Cook M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 12-24-41 year hour minute M.
21. I hereby certify that I attended the deceased from 11-50 P. to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Cause of death — Duration

Immediate cause of death: Acute pulmonary embolism
Due to: Deep veins thrombosis
Due to: Laceration of the lip
Other conditions (Include pregnancy within 3 months of death): Healing intertrochanteric
Major findings of operation: fracture of the femur
Of autopsy:

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): Accident
(b) Date of occurrence: Nov 20 1941
(c) Where did injury occur? Indep. (City or town) Mo (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? (Specify kind of business or industry)
23. Signature: Arthur Kuhlen (M. D. or other)
Address: K. C. Mo. Date signed

360 (Licensed Embalmer's Statement on Reverse Side)

MAR 12 1943

MAR 2 1942

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 Felix Perez

Licensed Embalmer No. 4127

P. O. Address K. 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.

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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STANDARD CERTIFICATE OF DEATH

State File No. 42018

Registration District No. 398 Primary Registration District No. 5554 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Mary Wallingford
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 28 (Day) 1886 (Year)

8. AGE: Years 54 Months 11 Days 28 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 24 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 — Duration
Ossification to st. Hip
Due to
Injury by fall
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
See memorandum attached
186a

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY