

FILED APR 25 1942

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1292

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3003 East 35th Street
(If not in hospital or institution, write street number or location) /
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community 37 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁰⁴⁸
(c) City or town Kansas City Missouri ³
(If outside city or town limits, write "RURAL")
(d) Street No. 3003 East 35th Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mrs Clara K. HEMENWAY

3. (b) If veteran, name war None 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 Unknown 6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased May 20 1883
(Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days 10 If less than one day
hr. min.

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

10. Usual occupation Wreckers Division

11. Industry or business Police Department

12. Name W.B. Keeton

13. Birthplace Unknown New York
(City, town, or county) (State or foreign country)

14. Maiden name Ella La Dieux

15. Birthplace Unknown New York
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Hemenway

(b) Address 3003 East 35th Street

17. (a) Burial (b) Date thereof 4-1-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Melody McGilley

(b) Address Kansas City Missouri

19. (a) 4-2-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30th
year 1942 hour 11 minute 30 P. 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 acute left heart failure Duration ✓

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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) _____

(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) Means of injury _____

23. Signature R. Paul Wright (M. D. or other) M.D.

Address St. Joseph's Hosp., K.C. Date signed 3-31-42

On 20 night

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..... *J. H. [Signature]*
Licensed Embalmer No. *3795*
P. O. Address..... *KC*

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 1292

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:
3003 E. 35th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Clara K. Hemmway

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 Months Days If less than one day
58 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 6101/42 M. M. Brown

19. (a) (Date received local registrar) (b) (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 March day 30th
year 1942 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 Acute left heart failure - congestive

Due to 93E
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 R. Paul Wright (M. D. or other M.D.)

Address St. Joseph's Hosp Date signed 6-3-42

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

9648