S. No. 2
M—9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9799 9936

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1061

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

48
3
8

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: 1119 East 45 St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 26 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 1119 East 45 St.
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Mary Walling

3. (b) If veteran, name war no

3. (c) Social Security No. 496-16-3654

4. Sex Femal

5. Color or race White

6. (a) Single, widowed, married, divorced divorced 3

6. (b) Name of husband or wife N.Z. Walling (Dead)

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

7. Birth date of deceased January 17th 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
68	1	24	..... hr. ..... min.

9. Birthplace Leavenworth Kansas 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Anderson
13. Birthplace Norway 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unk 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Cleo W. Scanland 1
(b) Address 1119 East 45 St.

17. (a) Entombment, Temple (b) Date thereof March 14-1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or Mt. Moriah

18. (a) Signature of funeral director Mrs C.L. Forster
(b) Address 918 Brooklyn Kansas City, Mo.

19. (a) 3-14-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 11-42
year ..... hour ..... minute 11:00 A M.

21. I hereby certify that I attended the deceased from Deputy Coro, 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Coronary Sclerosis

Due to

Other conditions 93 dt
(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 Russell Wagner (M. D. or other) 3

Address KCM Date signed

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(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 Me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed C. H. Nise

Licensed Embalmer No. 2570

P. O. Address Kansas City

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.