

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16914

State File No.

FILED JUN 6 1942
Registration District No. 375

Primary Registration District No. 100

Registrar's No. 2112

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution May 1, 1942
In this community 15 years
years, months or days

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson 3
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 433 South White
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME WILLIAM HARRISON CUNDIFF
3. (b) If veteran, name war no
3. (c) Social Security No. 493-12-8074

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day 5-30-42
year _____ hour _____ minute _____ M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Mary E. 6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased September 16, 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12:30 A.M.
_____, 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 _____

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>8</u>	<u>14</u>	_____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy yes

9. Birthplace Hardin, Kentucky
(City, town, or county) (State or foreign country)
10. Usual occupation Broom Maker
11. Industry or business Broom Factory

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy yes

MOTHER FATHER
12. Name Bluford Cundiff
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Hilton
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

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? _____ (Specify means of injury) _____

16. (a) Informant Lloyd A. Cundiff
(b) Address 1012 Washington St
17. (a) removal (b) Date thereof May 30, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Scandia, Kans
18. (a) Signature of funeral director Joyce
(b) Address 3146 Main St., Kansas City, Mo
19. (a) May 30 1942 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

23. Signature W. H. Miller (M. D. or other) D
Address K. C. Mo. Date signed _____

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

16914

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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..... *Paul S. Rowe*

Licensed Embalmer No. *2347*

P. O. Address *T. 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16914

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2112

1. PLACE OF DEATH: Jackson Kansas City
 (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:
 (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 William H. Cundess
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 16 1873
 (Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days _____ (If less than one day _____) 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) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
 19. (a) 9/2/42 (b) M. M. Brown
 (Open received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State 1 (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 May year 1942 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to Lung abscess
 Due to (not malignant or tubercular)
 Other conditions _____
 (Include pregnancy within 3 months of death) 114D

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?
 _____ (Specify type of place) _____ (e) Means of injury _____
 While at work? _____ (Specify type of place) _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

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

SUPPLEMENTARY

S-16914