

FILED NOV 9 1942 49

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 3874

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

1. PLACE OF DEATH:

(d) County JACKSON

(e) City or town KANSAS CITY MO.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: TRINITY LUTHERAN HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 DAYS  
(Specify whether years, months or days)

In this community 19 YRS.

3. (a) PRINT FULL NAME MRS. DITACLEN WOY.

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 MARRIED

6. (b) Name of husband or wife SILAS W. WOY

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased APRIL 22 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

54 5 27 hr. min.

9. Birthplace GREEN CITY MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name PRESTON MAUPIN.

13. Birthplace VIRGINIA  
(City, town, or county) (State or foreign country)

14. Maiden name CELESTINE ASH.

15. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant SILAS W. WOY

(b) Address 3417 CYPRESS

17. (a) REMOVAL (b) Date thereof 10-21-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREEN CITY MISSOURI

18. (a) Signature of funeral director MELLODY, M<sup>c</sup>GILLEY

(b) Address H. S. MO.

19. (a) 10-20-42 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY MO.  
(If outside city or town limits, write "RURAL")

(d) Street No. 3417 CYPRESS  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19 1942  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1930 to \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw her alive on 10/17/42, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatous

Due to Carcinoma of Rt. Breast

Due to 50

Other conditions Myocardial stenosis; Myocardial infarction; Left hydrocephalus  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy As noted above

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 John H. Ogilvie M.D. (M.D. or other)  
Address 730 Prof Bldg Date signed 10/20/42

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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. 2989

P. O. Address..... 155

**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.