S. No. 2
1—1-4-41
5-17-39
I X26390

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

1389

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. FILED FEB 10 1943 Primary Registration District No. 1002 Registrar's No. 436

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: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)
In this community 17 Months

2. USUAL RESIDENCE OF DEACESED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 5708 Forrest (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frances Whitford
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife J. S. Whitford
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March (Month) 7 (Day) 1856 (Year)

8. AGE: Years	Months	Days	If less than one day
86	10	19	hr. min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation House Keeper
11. Industry or business _____
12. FATHER Name John James Sisson
13. FATHER Birthplace Virginia (City, town, or county) (State or foreign country)
14. MOTHER Maiden name Sarah Ann T Thomas
15. MOTHER Birthplace Virginia (City, town or county) (State or foreign country)
16. (a) Informant Mrs Frank J Reed
(b) Address 5708 Forrest - Kansas City Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-28-43 (Month) (Day) (Year)
(c) Place: burial or cremation Olathe Kas.
18. (a) Signature of funeral director J. E. Julian
(b) Address Olathe Ks.
19. (a) 1/29/43 (Date received by local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26 year 1943 hour 2 minute 45 A. M.
21. I hereby certify that I attended the deceased from January, 1941, to January 26, 1943 that I last saw he alive on January 26, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Edema	1 day
Due to Myocarditis Chronic	3 yrs
Due to 925	
Other conditions Pneumonia terminal (Include pregnancy within 3 months of death)	2 days

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? _____ (Specify type of place)
While at work _____ (e) Means of injury _____
23. Signature D. Wyatt Waterman (M. D. or other)
Address 1002 Troy Bldg Date signed 1/29/43

(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.....

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

working under my personal supervision.

Signed H. E. Julian

Licensed Embalmer No. 2047

P. O. Address Olathe Kas.

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.