S. No. 2
M—2-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

5288

State File No.

FILED MAR 5 1943

Registration District No. 709

Primary Registration District No. 1002

Registrar's No. 813

48
38

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:
3309 Harrison /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community 38 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 3309 Harrison
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Rose Killday

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fe

5. Color or race Wh

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

6. (b) Name of husband or wife Thos. Killday

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Dec 11, 1873 (Month) (Day) (Year)

8. AGE: Years ~~70~~ 69 | Months 2 | Days 4 | If less than one day ___ hr. ___ min.

9. Birthplace Italy (City, town, or county) 5 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Chas. Sedlmayr
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name No record
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant Thos. Killday
(b) Address 3309 Harrison

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-43 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave.

19. (a) 5-16-43 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 15 year 43 hour 10 minute A M.

21. I hereby certify that I attended the deceased from 1-5, 1943, to 2-14, 1943; that I last saw her alive on 2-14-43 12 30 PM, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute myocardial insufficiency	
Due to Carcinoma of uterus c̄ metastasis throughout intestines	
Due to 114 B 10	
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) (e) Means of injury

23. Signature Wm Fowler (M. D. or other) DO

Address 3504 Troost Date signed 2-15-43

(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 Thos E Quick

Licensed Embalmer No. 3775

P. O. Address K 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.