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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

State File No. 5526

FILED FEB 27 1943

Registration District No. 1049

Primary Registration District No. 1002

Registrar's No. 694

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: 3930 Euclid Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 1 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48 3 8
(a) State Missouri (b) County
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3930 Euclid Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Mrs Claudia Sutlief

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fe

5. Color or race W.

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

6. (b) Name of husband or wife Not Known

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

7. Birth date of deceased 2 (Month) 25 (Day) 1863 (Year)

8. AGE: Years 79 Months 11 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace Mt. Vernon (City, town, or county) Indiana (State or foreign country)

10. Usual occupation At home

11. Industry or business

FATHER
12. Name Wm D Bailey
13. Birthplace (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Not known
15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Bessie E Winton
(b) Address 3930 Euclid Ave

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-9-43 (Month) (Day) (Year)
(c) Place: burial or cremation Atchison Kansas

18. (a) Signature of funeral director [illegible]
(b) Address K.C.K.

19. (a) 2-9-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 7 year 1943 hour ..... minute 108 M.

21. I hereby certify that I attended the deceased from Dec 15 1942 to Feb 7 1943 that I last saw h..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to [illegible]

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy No

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 F. E. Rumsey M D (M. D. or other)
Address 311 Argyle Bldg Date signed 2/9-43

(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 George M. Malloy

Licensed Embalmer No. 2798

P. O. Address Kansas City, Kan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.