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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 843

FILED MAR 5 1943
Registration District No. 149

Primary Registration District No. 1002

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

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:
Colonial Rest Home, 47611 Wornall Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mo (Specify whether
In this community 47 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mrs. Ada T. Wadsworth

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, Widowed
6. (b) Name of husband or wife C. W. Wadsworth 6. (c) Age of husband or wife if alive. --- years
7. Birth date of deceased. January 29 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 0 17 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Martha Scofield
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. David F. Hornbuckle

(b) Address 7735 McGee Street

17. (a) Burial (b) Date thereof 2-18-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 2-17-43 (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
(If outside city or town limits, write "RURAL")
(d) Street No. 7611 Wornall Road
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 16
year 1943 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from you
20 1943 to Feb 16 1943
that I last saw her alive on Feb 16 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia - Bronchial
Duration 2 days

Due to _____
Due to 107

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) Means of injury _____
23. Signature Professional Seal (M. D. or other) M.D.
Address _____ Date signed 2/17/43

Handwritten notes:
J. P. ...
4/4/31
after 10 m.

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..... *Clarence W. Childs*

Licensed Embalmer No..... *3473*

P. O. Address..... *6 E 7th St*

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.