

V. S. No. 2
50M-5-42
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

MAR 20 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1262

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:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days
(Specify whether years, months or days)

In this community 45 Years
(Specify whether years, months or days)

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. 2821 Lister
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Martha Ann Raymond

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11th.
year 1943 hour 2 minute 30 A.M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John S. Raymond

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

7. Birth date of deceased 5 - 12 - 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March, 1943, to 3 - 11 - 1943
that I last saw her alive on 3 - 10 - 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure
Duration

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>9</u>	<u>29</u>hr.min.

Due to Acute nephritis and pyonephritis

Due to

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

Other conditions Hemorrhagic cystitis
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

11. Industry or business

Major findings:
Of operations 125a

Of autopsy

PHYSICIAN
.....
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Henry Carter

13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name No Record
(City, town, or county) (State or foreign country)

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Homer N. Raymond

(b) Address 627 Newton

17. (a) Burial (b) Date thereof 3-13-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mrs. C. L. Forster
Kansas City, Missouri

(b) Address

19. (a) 3-13-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(c) Means of injury

23. Signature Clarence D. Copell (M. D. or other)
Address

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

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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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address R.L. me

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.