S. No. 2
M—5-42
v. 5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9348

FILED MAR 20 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1221

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 711 Bennington 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 58 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City, Mo. 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 711 Benington
(If rural, give location)

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

If yes, name country 2

3. (a) PRINT FULL NAME Mrs. Ellen Dwyer Way

3. (b) If veteran, name war -- 3. (c) Social Security No. None

4. Sex F 5. Color or race 1 6. (a) Single, widowed, married, divorced 2 Widow

6. (b) Name of husband or wife Joseph H. Way 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased July 26, 1874 (Month) (Day) (Year)

8. AGE: Years 68 Months 7 Days 12 If less than one day ..... hr. ..... min.

9. Birthplace Des moines (City, town, or county) Iowa 1 (State or foreign country)

10. Usual occupation ~~Des Moines,~~ ~~Iowa~~

11. Industry or business Housewife

FATHER
12. Name Michael Dwyer
13. Birthplace County Cork (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name ~~No Record~~ Ellen Dockery
15. Birthplace County Waterford, (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant C.T., H.O., and G.U. Way
(b) Address 711 Bennington

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11-43 (Month) (Day) (Year)
(c) Place: burial or cremation Mt St Marys Cemetery

18. (a) Signature of funeral director Sheil Funeral Home
(b) Address 6606 Indep. Ave., K.C.Mo.

19. (a) 3-10-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 8
year 1943 hour 11 minute 59 P.M.

21. I hereby certify that I attended the deceased from Jan 1 1943 to March 8 1943
that I last saw her alive on March 8 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma — Duration 3 days
Due to Diabetes Mellitus years
Due to ✓
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature E. W. Martin M.D. (M.D. or other)
Address 400 Camb. K.C. Mo. Date signed 3-10-43

(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.....

Licensed Embalmer No. 3625

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.