V. S. No. 2
50M—5-42
Rev. 5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 7 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

17051

State File No. .....

Registration District No. 149 — Primary Registration District No. 1002 — Registrar's No. 2061

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: Menorah Hospital, 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days, (Specify whether

In this community 65 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson, 3

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

(d) Street No. Villa Serena Apartment Hotel, 6 (If rural, give location)

321 Ward Parkway

(e) Citizen of foreign country? no. 0 (Yes or No)

If yes, name country x

3. (a) PRINT FULL NAME Mrs. Sarah Mooney Mayer

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed, 2

6. (b) Name of husband or wife David S. Mayer,

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

7. Birth date of deceased September (Month) 29 (Day) 1863 (Year)

8. AGE: Years 79 | Months 7 | Days 3 ~~4~~ | If less than one day ..... hr. ..... min.

9. Birthplace Illinois (City, town, or county) 1 (State or foreign country)

10. Usual occupation at home,

11. Industry or business x

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

MOTHER
14. Maiden name Hannah Meyer,
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant Stanley J. Mayer,

(b) Address Des Moines, Iowa,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-43 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 5-3-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd year 1943 hour 3:37 p minute P. M.

21. I hereby certify that I attended the deceased from for past 15 years, to May 2, 1943, 19..., that I last saw her alive on May 2, 1943, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to Myocarditis Arteriosclerosis also Carcinoma of rectum

Due to .....

Other conditions (Include pregnancy within 3 months of death) 46

Major findings:
Of operations .....
Of autopsy .....

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 Fred Irwig, M. D. (M. D. or other)

Address 1610 Prof. Bldg., Date signed May 3, 1943

(Licensed Embalmer's Statement on Reverse Side)

Dr. Fred Irwig
1:30

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. 4179

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.