

S. No. 2
M-2.43
5-17-39
I X35

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30922

State File No. _____
3966
Registrar's No. _____

FILED SEP 28 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:
4501 Jackson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 24 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. 4501 Jackson
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret F. Rice

3. (b) If veteran, name war none 3. (c) Social Security No. 486-03-3640

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John T. Rice 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased June 1 1918
(Month) (Day) (Year)

8. AGE: Years 25 Months 3 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business none

12. Name George H. Holmstrom

13. Birthplace Sweden
(City, town, or county) (State or foreign country)

14. Maiden name Mary F. Haas

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

16. (a) Informant John T. Rice

(b) Address 4501 Jackson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep. 15, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. Signature of funeral director T. J. Steinbacher

(b) Address 3146 Main St.

19. (a) 9-15-43 (b) J. E. Brown, Dep.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9-13th day September
year 1943 hour 5 minute 25 A.M.

21. I hereby certify that I attended the deceased from May 13 1943 to Sept 13 1943
that I last saw her alive on Sept 13, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Uterine Cervix

Due to Unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None necessary

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 DR. EDWARD H. SKINNER
Address 1532 Professional Bldg Date signed 9/17/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(Licensed Embalmer's Statement on Reverse Side)

KANSAS CITY 6, MO.

OCT 22 1945

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.....

Guy P. Buffington

Licensed Embalmer No.....

2756

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.