

No. 2
1-2-43
5-17-39
X3589

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32858

State File No. _____
Registrar's No. 4249

ED NOV 1 1943/49
Registration District No. _____

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:
216 East 34th Terrace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community most of her life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Mary Amelia McDaniel Long
(b) If veteran, name war no.
(c) Social Security No. no.

4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife A. B. McDaniel
(c) Age of husband or wife if alive dec. years
7. Birth date of deceased: August 13 1853
(Month) (Day) (Year)

8. AGE: Years 90 Months 1 Days 22 If less than one day .hr. : min.

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

10. Usual occupation at home

11. Industry or business X

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

16. (a) Informant Mrs. C. J. Aldroyd
(b) Address 216 E. 34th Ter., Kansas City, Mo.

17. (a) Cremation (b) Date thereof 10-8-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 10-6-43 (b) P. E. 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. 216 East 34th Terrace
(If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 6th
year 1943 hour 11:20 minute AM

21. I hereby certify that I attended the deceased from 10/5-1943
19 to 19
that I last saw h. alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage
Duration 3

Due to Arterio Sclerosis
Due to 8301

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____

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)
(e) Means of injury _____
23. Signature R. F. ... (M. D. or other)
Address 5400 St. ... Date signed 10/6/43

Dr. Robert A. Williams,

5100 St. John

2 to 6 P.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 E. M. Plank

Licensed Embalmer No. 1848

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.