

7. S. No. 2
M-9-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40874

State File No.

FILED JAN 5 1944/9
Registration District No.

Primary Registration District No. 1002

Registrar's No. 5392

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 K.C.T.B. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 d. (Specify whether years, months or days) 2 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

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

(d) Street No. 6220 Front ⁸
(If rural, give location)

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

3. (a) PRINT FULL NAME Orda Jeanette Cantrell

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fem 5. Color or race wh

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased April 10 1885
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16
year 1943 hour 12-15 minute A. M.

21. I hereby certify that I attended the deceased from 12-11-43
19 43 to 12-16 19 43
that I last saw her alive on 12-16 19 43
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>8</u>	<u>6</u>	hr. min.

Immediate cause of death Massive Mastic Haemorrhage acute

Due to Mastic ulcers. ^{1 yr.}

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

Other conditions Pulmonary Tuberculosis ^{6 mos}
(Include pregnancy within 3 months of death)

10. Usual occupation Helper

Major findings: Of operations 13 1/1

Of autopsy same

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business Beauty Parlor

12. Name Joseph W. Frye

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

14. Maiden name Ethel Kaiser

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

16. (a) Informant Mrs A C Austin

(b) Address 4829 W 61, Mission Kas

17. (a) Removal (burial, cremation, or removal) (b) Date thereof 12-16-43
(Month) (Day) (Year)

(c) Place: burial or cremation Joseph, Kas

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?

18. (a) Signature of funeral director Gene F. McClure

(b) Address 3235 Millham Plaza KC Mo

19. (a) 12-20-43 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

While at work? (Specify type of place)

(c) Means of injury 0

Signature Matthew J. Noon (M. D. or other)

Address K.C.T.B. Hosp. Date signed 12-16-43

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..... *John F. Purley*
Licensed Embalmer No. *4050*
P. O. Address *Kansas City, 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.