

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1202**  
**316**  
Registrar's No.

Registration District No. **149**

Primary Registration District No. **1002**

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: **General Hospital # 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10 days**  
(Specify whether years, months or days) **10 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **1618 Washington Kansas**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Kansas City**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Maggie Anglin**

3. (b) If veteran, name war **No**  
3. (c) Social Security No. **490-16-2888**

4. Sex **F** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **wid.**

6. (b) Name of husband or wife **Unknown**  
6. (c) Age of husband or wife if alive **14** years (Day) (Year)

7. Birth date of deceased **Nov 14, 1882**  
(Month) (Day) (Year)

8. AGE: Years **61** Months **2** Days **6**  
If less than one day hr. min.

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

10. Usual occupation **Home**

11. Industry or business

12. Name **Albert Woolery**

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

14. Maiden name **Mary Cot**

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

16. (a) Informant **Mrs Mary Brooks**

(b) Address **1618 Washington**  
**Warrensburg Mo**

17. (a) Date thereof **1-20-44**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Warrensburg Mo**

18. (a) Signature of funeral director **Stevens & McCluskey**

(b) Address **111 E. Main**  
(c) Date received local registrar **Jan 20 1944**  
(Registrar's signature) **E. Brown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **20**  
year **1944** hour **2** minute **40** P. M.

21. I hereby certify that I attended the deceased from **Jan 10**  
**1944** to **Jan 20 4:40**  
that I last saw her alive on **Jan 20 4:40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lung abscess- empyema left.**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)  
Major findings: **N.M.O.**  
Of operations  
Of autopsy **See above**

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) (c) - Means of Injury  
23. Signature **A. E. Usher** (M. D. or other)  
Address **23rd & N. E. 1st** Date signed

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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**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.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**