

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 19 1943

5630

Registration District No. 149Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

## 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:  
Conley Clinical Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 Days  
(Specify whether  
 In this community 10 Days  
years, months or days)

3. (a) PRINT FULL NAME Maude Augusta Heron3. (b) If veteran, name war No 3. (c) Social Security No. None4. Sex Fe. 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 65 years7. Birth date of deceased August 23, 1872  
(Month) (Day) (Year)8. AGE: Years 71 Months 4 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Unknown  
(City, town, or county) (State or foreign country)10. Usual occupation Homemaker11. Industry or business None12. Name Unknown13. Birthplace Unknown  
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown  
(City, town, or county) (State or foreign country)16. (a) Informant Peery Moore(b) Address 6200 Wilson17. (a) Burial (b) Date thereof 12/31/43  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Green Lawn Cemetery18. (a) Signature of funeral director C. H. Blackman & Son, Inc.(b) Address Kansas City, Mo.19. (a) Dec 30, 1943 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 957 Osage  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 2

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 30  
year 1943 hour 12 minute 45 A.M.21. I hereby certify that I attended the deceased from Nov. 1929  
1929 to Dec. 30, 1943  
that I last saw her alive on Dec. 29, 1943  
and that death occurred on the date and hour stated above.Immediate cause of death acute myocarditis  
Duration 12 hrDue to acute pneumonia  
and influenzaDue to acute pneumonia 12 da  
and influenza 14 da  
Other conditions chronic nephritis  
(Include pregnancy within 3 months of death)Major findings: none 131 P PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_Of autopsy none  
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) \_\_\_\_\_  
 (a) While at work? \_\_\_\_\_ (c) Means of Injury fall  
 23. Signature Margaret Moore (M.D. or other) M.P.  
 Address 3639 St. Kl., M.D. Date signed 12-30-43

**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..... *H. D. Blackman*

Licensed Embalmer No. *3639*

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.**