DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5601

FILED JAN 19 1944

Registration District No. 1/49

Primary Registration District No. 1002

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Lukes O Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 Hours (Specify whether

In this community 1 1/2 Years (years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Mo (b) County Jackson

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

(d) Street No. R R # 4 No Kan City (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Cyrene - McMains

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Wren McMains

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Dec (Month) 30 (Day) 1911 (Year)

8. AGE: Years 31 32 | Months X | Days X 28 | If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Rufus Helm
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ester Cooney

(b) Address R.R# No K C Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-43 (Month) (Day) (Year)

(c) Place: burial or cremation Richmond - Ind.

18. (a) Signature of funeral director Marlon Funeral Fl

(b) Address No Kan City Mo

19. (a) Dec 29 1943 (Date received local registrar) (b) F G Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27th year 1943 hour 330 minute P M.

21. I hereby certify that I attended the deceased from Dec 26, 1943, to Dec 27, 1943 that I last saw her alive on Dec 27, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death acute toxic cardiac dilatation

Due to anesthesia probably thro not conclusively

Due to

Other conditions Pregnancy at term (Include pregnancy within 3 months of death)

Major findings:
Of operations 145 1/2

Of autopsy As above

Duration

PHYSICIAN

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)

While at work? ✓ (e) Means of injury ✓

23. Signature Maurice L Jones (M. D. ~~or other~~)

Address St Lukes Hospital Date signed 12-28-43

361

(Licensed Embalmer's Statement on Reverse Side)

Yl 4960
Mr Mc Naughton

AUG 31 1955

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 S. Morton

Licensed Embalmer No. 4349

P. O. Address No Kan City

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

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