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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5980

FILED FEB 18 1944

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 536

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: 3644 WOODLAND AVENUE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution --- (Specify whether
In this community 24 YEARS
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. 3644 WOODLAND AVENUE 8
(If rural, give location)

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

If yes, name country ---

3. (a) PRINT FULL NAME MRS STATIRA C. CECIL

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MR JAMES BUCHANAN CECIL

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

7. Birth date of deceased MAY (Month) 6 (Day) 1862 (Year)

8. AGE: Years 81 Months 8 Days 25 If less than one day hr. min.

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

10. Usual occupation AT HOME

11. Industry or business ---

FATHER
12. Name ROBERT SNODGRASS
13. Birthplace (City, town, or county) UNKNOWN (State or foreign country)

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

16. (a) Informant S. R. Cecil
(b) Address 7321 Montgall

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 00 3 1944 (Month) (Day) (Year)

(c) Place: burial or cremation LEON KANSAS

18. (a) Signature of funeral director D. H. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 2-2-44 (Date received local registrar) (b) T E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 1 ST year 1944 hour 1 minute A M.

21. I hereby certify that I attended the deceased from Jan 20, 1944 to Feb 1, 1944 that I last saw her alive on Jan 31, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Mitral Insufficiency	
Due to: Valvular Heart Lesion	1 year
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 Carl Jackson (M. D. or other) O. M.

Address 1103 E Armour Date signed 2-1-44

(Licensed Embalmer's Statement on Reverse Side)

1103 East Armour Blvd
11-4

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. C. Newcomer Jr

Licensed Embalmer No. 4043

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.