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M-2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6243**  
Registrar's No. **648**

**FILED FEB 21 1944**  
Registration District No. **1002**

Primary Registration District No. **1002**

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: Home 13546 Indel  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community 18 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Jackson

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

(d) Street No. 3546 Indiana  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** MRS MARY NAU

3. (b) If veteran, name war no

3. (c) Social Security No. none

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 7  
year 1944 hour 9 minute 9 M.

21. I hereby certify that I attended the deceased from Jan 10  
1943 to Feb 7, 1944  
that I last saw her alive on Feb 6, 1944  
and that death occurred on the date and hour stated above.

4. Sex Fe

5. Color or race wh

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

6. (b) Name of husband or wife un R

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

7. Birth date of deceased April 16 - 1858  
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion

Due to \_\_\_\_\_

Due to Diabetes Mellitus

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration 1 Day

3 years

8. AGE: Years 82 Months 9 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

**PHYSICIAN**

Major findings: Of operations \_\_\_\_\_

Of autopsy no

Underline the cause to which death should be charged statistically.

**11. Industry or business** \_\_\_\_\_

**MOTHER FATHER**

12. Name John Joseph

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Deat Knue 9

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Nau

(b) Address 3546 Indiana

17. (a) Burial (b) Date thereof 2-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director C.D. Max memorial Home

(b) Address 346 Deat

19. (a) 2-8-44 (b) T.B. Brown (V3)  
(Date received local registrar) (Registrar's signature)

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)

(a) Means of injury 3

23. Signature John R. Lewis (M. D. or other) M.D.

Address 3548 Indiana Date signed 2-7-43

**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 Howard J. Roe

Licensed Embalmer No. 2745

P. O. Address 1346 East Ave.

**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.**