

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6309  
825  
Registrar's No.

Registration District No. LED MAR 6 1944/49

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: RESEARCH HOSPITAL 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 DAYS  
(Specify whether years, months or days)

In this community 32 YEARS  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON <sup>48</sup>

(c) City or town KANSAS CITY <sup>9</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 1223 EAST-11TH STREET  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME MRS. EUDIAN FRANCES SAUNDERS

(b) If veteran, name war No

(c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 16 <sup>TH</sup>  
year 1944 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb 12  
1944, to Feb 16 1944;  
that I last saw her alive on Feb 16 1944;  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. A. E. SAUNDERS

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased SEPTEMBER 2 1911  
(Month) (Day) (Year)

Immediate cause of death religion pulmonary

Duration had been

8. AGE: Years Months Days If less than one day

32 5 14 hr. min.

Due to -

Due to -

Other conditions: -  
(include pregnancy within 3 months of death)

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

10. Usual occupation HOUSEWIFE

11. Industry or business -

MOTHER FATHER { 12. Name ARCHIE L. TRACY

13. Birthplace CINCINNATI OHIO  
(City, town, or county) (State or foreign country)

14. Maiden name FANNIE L. STOLL

15. Birthplace COVINGTON VIRGINIA  
(City, town, or county) (State or foreign country)

Major findings: 136

Of operations -

Of autopsy -

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

16. (a) Informant MR. A. E. SAUNDERS

(b) Address 1223 EAST-11TH STREET

17. (a) BURIAL (b) Date thereof FEB 19 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

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? -

18. (a) Signature of funeral director W. H. Newcomb, Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 2-19-44 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

While at work? - (Specify type of place) (e) Means of injury 0

23. Signature libby d (M. D. or other) 0

Address 3850 Prairie Date signed 2-19-44

3850 Project

2

**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*

Licensed Embalmer No. 4043

P. O. Address H. C. Newcomer

**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.