o. 2
-43
7-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 [redacted]

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20873

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2720

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:
Little Sisters of Poor 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mo. (Specify whether
In this community 3 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3 8

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

(d) Street No. 5331 Highland Ave.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 10

3. (a) PRINT FULL NAME MARY SHIRLEY

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 Wd. 2

6. (b) Name of husband or wife No Record

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

7. Birth date of deceased July (Month) 20 (Day) 1873 (Year)

8. AGE: Years 70 Months 11 Days 8 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name William McLellan
13. Birthplace (City, town, or county) No Record 9 (State or foreign country)

MOTHER
14. Maiden name Mary Anne Fuesley
15. Birthplace (City, town, or county) No Record 9 (State or foreign country)

16. (a) Informant Sister St Thiele
(b) Address 5331 Highland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/1944 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director Quirk & Cohen Co
(b) Address 20 West Linwood Blvd

19. (a) 6-29-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 28
year 1944 hour 8: minute 00 A.M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Myocardial failure	1 day
Due to Myocardosis	yrs.
Due to Cardio hepato renal arteriosclerosis	yrs
Other conditions (Include pregnancy within 3 months of death)	

131a

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 Dr John T. Skinner (M. D. or other) MD
Address 1102 Grand Ave K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.