

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JUN 29 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 2561

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:  
4401 East 53rd Terr.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 4 Months \_\_\_\_\_  
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. 4401 East 53rd Terr. 8  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Myrtle Wagner

3. (b) If veteran, name war No

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15th  
year 1944 hour 4 minute P M.

21. I hereby certify that I attended the deceased from April 24, 1944 to June 15, 1944  
that I last saw h. or alive on June 14, 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 Widowed

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

7. Birth date of deceased March 25 1875  
(Month) (Day) (Year)

Immediate cause of death Decompensated Myocarditis

Due to Carcinoma of liver + gall bladder

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

Other conditions (Include pregnancy within 3 months of death) 46k

Duration 3 wks approx.  
1/65 sig

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day  
69 2 20 hr. min.

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

10. Usual occupation Housewife

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

12. Name H. McCoy

13. Birthplace Unknown Penn.  
(City, town, or county) (State or foreign country)

14. Maiden name Rosa Cook

15. Birthplace Unkown Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ollie Danner

(b) Address 4401 East 53rd Terr.

17. (a) Removal 1944 (b) Date thereof 6-16-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Removal Butler, Mo.

18. (a) Signature of funeral director Arthur R. Gog

(b) Address Kansas City, Missouri

19. (a) 6-17-44 (b) H. E. Burton  
(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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature J. J. Focik (M. D. or other) DO

Address 5908 St. John Date signed 6/16/44

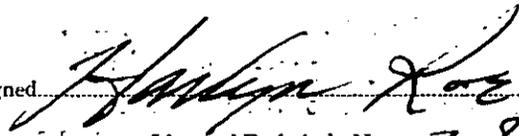
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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. 2810

P.O. Address 176. 2nd

**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.**