20933

o. 2
3-43
7-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2820

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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community 20 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") 8

(d) Street No. 2606 Chestnut
(If rural, give location)

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

3. (a) PRINT FULL NAME MARY JEANE WEST

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe.

5. Color or race White

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

6. (b) Name of husband or wife Russell O.

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Oct. 7, 1887 (Month) (Day) (Year)

8. AGE: Years 56 Months 8 Days 28 If less than one day hr. min.

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

10. Usual occupation Homemaker

11. Industry or business At Home

FATHER
12. Name David R. Stills
13. Birthplace (City, town, or county) Pa. (State or foreign country)

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

16. (a) Informant Russell West
(b) Address 2606 Chestnut

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof July 7, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.
(b) Address Kansas City, Mo.

19. (a) 7-6-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 5, day
year 1944 hour 12 minute 15 A. M.

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

Immediate cause of death Myocardial failure associated with a hemorrhagic enteritis and early peritonitis

Due to multiple partial intestinal obstruction.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 0

23. Signature Loraine Sherwood (M. D. ~~or other~~)

Address Pathologist, St. Joseph Hosp. Date signed 7-5-44

(Licensed Embalmer's Statement on Reverse Side) K. C., Mo.

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 D Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.