

**FILED OCT 2 1944**  
199

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

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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS (Specify whether)

In this community 42 YEARS years, months or days

**3. (a) PRINT FULL NAME** MR. JOHN WEST MAYHUGH

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. ANNA BRIDGER MAYHUGH

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

7. Birth date of deceased MAE 14 1874  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>70</u>	<u>4</u>	<u>4</u>	hr. _____ min. _____

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

10. Usual occupation OWNER

11. Industry or business PIONEER PRINTING COMPANY

12. Name John T. MAYHUGH

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

14. Maiden name Ann West

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

16. (a) Informant Mrs. Anna B. Mayhugh

(b) Address 5739 Harrison

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept 19 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director D. V. Newcomer, Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 9-19-44 (Date received local registrar)

(b) D. E. Brown (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County JACKSON

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

(d) Street No. 5739 HARRISON STREET  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month SEPT. day 18<sup>TH</sup>  
year 1944 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 9/17 to 9/17, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death lung metastasis of carcinoma  
Cancer Recto sigmoid.

Due to metastases to Livers  
Glands above left  
Clavical.

Other conditions 462

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Carcinoma  
Recto sigmoid, Livers, Glands.

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)

(e) Means of injury \_\_\_\_\_

23. Signature C. J. Hunt (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

1612 Professional Body  
2-4

**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 Jr.*  
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.**