

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 26 1944
1949

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,
Kansas City,

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3715 Harrison,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no. (Specify whether _____)

In this community 6 years,
years, months or days

3. (a) PRINT FULL NAME Mrs. Alice Monfort

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Martin Monfort 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased January 3 1861
(Month) (Day) (Year)

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

83 8 11 _____ hr. _____ min.

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

10. Usual occupation at home,

11. Industry or business x

12. Name Unknown,

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

14. Maiden name unknown,

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

16. (a) Informant Miss Althea Robinson,

(b) Address 3715 Harrison, Kansas City, Mo.

17. (a) Burial, (b) Date thereof 9-16-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Butler, Missouri

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 9-15-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 4/

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

(d) Street No. 3715 Harrison,
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14th
year 1944 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 14, 1944 to Sept. 14, 1944
that I last saw her alive on Sept. 14, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Duration 2 hrs.

Due to Cerebral arteriosclerosis
many
year.

Due to _____

Other conditions (Include pregnancy within 3 months of death) 83a1

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature N. E. Brown (M. D. or other) _____
Address 522 Professional Bldg Date signed 9-15-44

Dr. Kenneth Lockwood

Prof. Billy

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 *Paul J. Ballew*.....

Licensed Embalmer No. *4206*.....

P. O. Address *K. C. Missouri*.....

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.