

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 13 1944

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 4330

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:
6025 BROOKSIDE BLVD.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 3 MONTHS
years, months or days)

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. 6025 BROOKSIDE BLVD.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. MAUD McCRORY

3. (b) If veteran, name war No
3. (c) Social Security No. 432-28-8757

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife MR. SCOTT HICKS McCRORY
6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased NOVEMBER 4 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 11 22 hr. _____ min.

9. Birthplace MT. STERLING OHIO
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

12. Name HARRY ESTES

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

14. Maiden name UNKNOWN

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

16. (a) Informant MISS ANNETTE F. TOMPINS

(b) Address 6025 BROOKSIDE BLVD.

17. (a) BURIAL (b) Date thereof OCT-28-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEM.

18. (a) Signature of funeral director D. H. Newcomer

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 1028-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 26 TH
year 1944 hour 8 minute 30 A.M.

I hereby certify that I attended the deceased from June 27
1944 to October 26, 1944
that I last saw her alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Angina pectoris

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 94 lb

Major findings:
Of operations _____
Of autopsy _____

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 J. G. Montanary (M.D. or other) _____
Address 1028-44 Date signed 10/27/44

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

