

S. No. 2  
M-2-43  
5-17-39

PI X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1009

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

FILED JAN 26 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 127

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:  
SENATE APT. HOTEL-1015 EAST ARMOUR  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_

In this community 50 YEARS 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON <sup>48</sup>

(c) City or town KANSAS CITY <sup>3</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. SENATE APT. HOTEL-1015 EAST ARMOUR  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. TINA FRANKLIN CARMODY

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 8<sup>TH</sup>  
year 1945 hour 11 minute 20 A.M.

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

6. (b) Name of husband or wife MR. WILLIAM H. CARMODY 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased NOVEMBER-9-1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
Carmody  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>1</u>	<u>29</u>	hr. _____ min. _____

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

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

10. Usual occupation AT HOME

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

Other conditions (Include pregnancy within 3 months of death) 430

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

12. Name ALBERT FARRELL

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

14. Maiden name EUGENIA WARD

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

Major findings: Of operations History & Inspection

Of autopsy no

16. (a) Informant Mr. P. D. Bennett

(b) Address 2607 Blue Sk St. Joplin, Mo.

17. (a) BURIAL (b) Date thereof JAN. 10 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director D. N. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 1-10-45 (b) P. E. Brown  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

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

23. Signature James E. Walker (M. D. or other) Carmody

Address 1424 Profen Alley Date signed 1-9-45

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

MOTHER FATHER

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**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.....

*4045*

P. O. Address.....

*K @ Mo.*

**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.**