

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 26 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1121

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 131

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:
General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-15-44-1-8-45
(Specify whether years, months or days) 40 yrs

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. 2404 Paseo
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MYRTLE GARR
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female **5. Color or race** Negro
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 23 1885
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 18
If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER

12. Name Unknown
13. Birthplace Unkn
14. Maiden name Unkn
15. Birthplace Mo

16. (a) Informant Record Clerk
(b) Address Gen. Hosp. #2.

17. (a) Burial, cremation, or removal Normal
(b) Date thereof 1-11-45
(Month) (Day) (Year)
(c) Place: burial or cremation Lexington Mo

18. (a) Signature of funeral director Lydia

(b) Address 1729
19. (a) Date received local registrar 1-10-45
(b) Registrar's signature N. E. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8
year 1945 hour 4:30 minute 8 M.
21. I hereby certify that I attended the deceased from
November 15 1944 to January 8 1945
that I last saw her alive on January 8 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis **Duration** _____

Due to Hypertensive type heart disease

Due to _____

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

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 Gen. Hosp. #2-600 E 22 **Date signed** 1-9-45

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

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.....

W J Manlove

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.