

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **8548**
Registrar's No. **1146**

FILED MAR 29 1945
Registration District No. **199**

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:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo.
(Specify whether years, months or days)
 In this community 47 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. 3001 De Groffway
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Ruth Demoney
 3. (b) If veteran, name war no 3. (c) Social Security No. no

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month March day 9
 year 1945 hour 4 minute 45 P.M.

4. Sex Femal / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Harold R. DeMoney 6. (c) Age of husband or wife if alive 47 years
 7. Birth date of deceased June 6 1897
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 8, 1945, to March 9, 1945;
 that I last saw her alive on March 9, 1945;
 and that death occurred on the date and hour stated above.
 Immediate cause of death General paresis *Duration*

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>69</u>	<u>3</u>	hr. _____ min. _____

Due to _____
 Due to _____ 30 B
 Other conditions See above
(Include pregnancy within 3 months of death)

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

Major findings:
 Of operations _____
 Of autopsy See above
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name Ebeneze Muir
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name Lena Bowen
 15. Birthplace Illinois
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Harold De Money
 (b) Address 3001 De Groff Way
 17. (a) Burial (b) Date thereof March 12 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt Washington Cem.
 18. (a) Signature of funeral director Mrs. C. J. Forster
 (b) Address 918 Brooklyn
 19. (a) 3-12-45 (b) H. E. Brown
(Date received local registrar) (Registrar's signature)

While at work? _____
(Specify type of place) (e) Means of injury
 23. Signature Clark W. Kelly M.D. or other _____
 Address Med. Dir. Gen'l Hosp Date signed 3-10-45

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 Theron A. Redman
Licensed Embalmer No. 2737
P.O. Address H. P. Me

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.