

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12068
Registrar's No. 1920

FILED MAY 15 1945

Registration District No. 749 Primary Registration District No. 1002

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days) 2 days 20 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. 3711 E. 9th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mattie B Chuning
3. (b) If veteran, name war No
3. (c) Social Security No. NO

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife J.I. Chuning
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased: Dec 4 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 26 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name No Record

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

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant J.I. Chuning

(b) Address 3711 East 9 St.

17. (a) Removal (b) Date thereof May 1 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound City Mo.

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address 918 Brooklyn

19. (a) 5-1-45 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 30
year 1945 hour 4 minute 05 P.M.
21. I hereby certify that I attended the deceased from April 29 1945 to April 30 1945;
that I last saw her alive on April 30 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death pneumococccic meningitis
Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 81a

PHYSICIAN
Major findings:
Of operations
Of autopsy see above
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?

(Specify type of place) While at work Means of injury 83
Signature Clark Seely (M.D. or other)
Address 11 K.C. Gen'l Hosp Date signed

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

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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.....

E H Wise

Licensed Embalmer No.....

2570

P. O. Address.....

15 @ Mrs

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.