No. 2
-2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15957

Registration District No. FILED JUN 11 1939 Primary Registration District No. 1002 Registrar's No. 2347

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~~: OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 2-DAYS (Specify whether
In this community 64 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 2505 WALROND AVENUE
(If rural, give location)

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

If yes, name country ---

3. (a) PRINT FULL NAME MR. REUBEN NEAL McQUERREY

3. (b) If veteran, name war No

3. (c) Social Security No. 500-03-9934

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of ~~husband~~ or wife MRS. BESSIE McQUERREY

6. (c) Age of husband or wife if alive ---- years

7. Birth date of deceased DECEMBER (Month) 1 (Day) 1880 (Year)

8. AGE: Years 64 Months 5 Days 28 If less than one day ___ hr. ___ min.

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

10. Usual occupation EMPLOYEE

11. Industry or business RUPERT DIECASTING COMPANY

FATHER
12. Name ABNER McQUERREY
13. Birthplace UNKNOWN (City, town, or county) KENTUCKY (State or foreign country)

MOTHER
14. Maiden name SARAH BRYANT
15. Birthplace UNKNOWN (City, town, or county) KENTUCKY (State or foreign country)

16. (a) Informant MRS. FRANK LIGHTHIZER

(b) Address 2517 WALROND AVENUE

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

(c) Place: burial or ~~cremation~~ ELMWOOD CEMETERY

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

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 5-31-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 29TH year 1945 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from 5-25-45, 19__, to 5-29-45, 19__; that I last saw him alive on 5-29-45, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bi Lat. Lobar - Pneumonia	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 108	

Major findings:
Of operations
Of autopsy Bi Lat Lobar Pneumonia

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr. C. J. Penfield (M. D. or other)

Address 4748 Prospect KCMo Date signed 5-29-45

(Licensed Embalmer's Statement on Reverse Side)

4148 [redacted] Prospect
2-6

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. 4043

P. O. Address K C 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.