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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26510

FILED SEP 10 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3641

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2721 Benton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 6 years -
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town 2721 Benton 48
(If outside city or town limits, write "RURAL")

(d) Street No. Kansas City 3
(If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME NAOMA MINERVA McCLOUGHAN-

3. (b) If veteran, name war no ✓

3. (c) Social Security No. none

4. Sex FE

5. Color or race W

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

6. (b) Name of husband or wife SAMUEL A.

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

7. Birth date of deceased NOVEMBER (Month) 10 (Day) 1863 (Year)

8. AGE: Years 81 | Months 9 | Days ~~29~~ | If less than one day 21 hr. ..... min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business ✓

FATHER
12. Name CHARLES A. CHAFFEE
13. Birthplace -No INFORMATION- (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name AMANDA CONKLIN
15. Birthplace -No INFORMATION- (City, town, or county) (State or foreign country)

16. (a) Informant MRS. WILLIAM HOGEL

(b) Address 2721 BENTON

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 4-45 (Month) (Day) (Year)

(c) Place: burial or cremation Goldsberry, Mo.

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

(b) Address 918-920 Brooklyn -

19. (a) 9-1-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1 year 1945 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from 1944, 19..., to Sept 1, 1945 that I last saw her alive on Sept 1, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Thrombosis

Due to arterial Sclerosis (Senile)

Due to .....

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

Major findings:
Of operations No 94a

Of autopsy No

Duration

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 0

23. Signature James T. Ferguson M. D. or other M.D.

Address 410 Bryant Bld Date signed 9/1/45

(Licensed Embalmer's Statement on Reverse Side)

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 Joe B. Yoder

Licensed Embalmer No. 4173

P. O. Address 918 Brooklyn

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.