

U.S. No. 2  
DM-8-43  
Rev. 5-17-39  
X37823

**FILED SEP 12 1945**  
Registration District No. **150**

Primary Registration District No. **5572**

Registrar's No. **114**

**1. PLACE OF DEATH:**  
 (a) County **Jackson**  
 (b) City or town **Rural Prairie**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution **Jackson County Emg. Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **2 mo 19 da.**  
(Specify whether years, months or days)  
 In this community **50 years.**

**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. **308 Garfield**  
(If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Mary ANN McNeil**  
 3. (b) If veteran, name war **no**  
 3. (c) Social Security No. **no**  
 4. Sex **Female** 5. Color or race **wh.**  
 6. (a) Single, widowed, married, divorced **W**  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **May 16 1859**  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month **August** day **31**  
 year **1945** hour **7** minute **00** A.M.  
 21. I hereby certify that I attended the deceased from **June 12-1945** to **Aug. 26-1945**  
 that I last saw her alive on **Aug. 26 1945** and that death occurred on the date and hour stated above.

**8. AGE:**  
 Years **86** Months **3** Days **15**  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Anemia**  
 Duration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions **W**  
(Include pregnancy within 3 months of death)

9. Birthplace **MO**  
(City, town, or county) (State or foreign country)  
 10. Usual occupation **at home**

**PHYSICIAN**  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy **W**  
 Underline the cause to which death should be charged statistically.

**11. Industry or business**  
 12. Name **Milton Brown**  
 13. Birthplace **Ky**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Wiley**  
 15. Birthplace **Wash Ky**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Arthur Wilcoxson**  
 (b) Address **2855 E. 6 K.C. Mo.**  
 17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **8-31-45**  
(Month) (Day) (Year)  
 (c) Place: burial or cremation **Maryville Mo.**

**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 \_\_\_\_\_

**18. (a) Signature of funeral director** **Stana P. McClure**  
 (b) Address **3235 Hillborn Plaza K.C. Mo.**  
 19. (a) **SEP 1-45** (Date received local registrar)  
 (b) **E. M. Schuch** (Registrar's signature)

23. Signature **E. W. Tuttle** (M. D. or other) **MD**  
 Address **Blue Springs Mo** Date signed **9/2/45**

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

MOTHER FATHER

**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 Robert H. Reed

Licensed Embalmer No. 3745

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.**