

S. No. 2
M-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED NOV 14 1945 STANDARD CERTIFICATE OF DEATH

32803

State File No. _____
Registrar's No. **4445**

Registration District No. 149 Primary Registration District No. 1002

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

18
3
8

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:
5126 Paseo Kansas City, Mo /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether
In this community 40 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 5126 Paseo
(If rural, give location)

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

If yes, name country. X

3. (a) PRINT FULL NAME Miss Elinor E. Megredy

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife X

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

7. Birth date of deceased October 20 -
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>about 76</u>	<u>✓</u>	<u>7</u>	hr. _____ min.

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

10. Usual occupation at home

11. Industry or business X

MOTHER FATHER {

12. Name John Megredy

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

14. Maiden name unknown

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

16. (a) Informant Norman Gordon

(b) Address Scarritt Bldg., Kansas City, Mo.

17. (a) Burial (b) Date thereof 10-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 10-29-45 (b) Geraldine Helms
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1945 hour 8 minute 30 M.

21. I hereby certify that I attended the deceased from Oct 23, 1945, to Oct 27, 1945
that I last saw her alive on Oct 25, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure

Due to Metastatic carcinoma of mediastinum

Due to Metastasis from st breast carcinoma

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

50

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature Edward A. Samuelson (M. D. or other)

Address 2603 331 K.C. Mo Date signed Oct 28-45

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

J. B. Allen

Licensed Embalmer No. 1415

P. O. Address H. E. No.

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.