

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 29 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4268

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

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: 3817 Benton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 7.5 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs MOLLIE MOUNT

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F. 5. Color or race W.

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

6. (b) Name of husband or wife James W. Mount

6. (c) Age of husband or wife if alive 91 years

7. Birth date of deceased: 9 (Month) 8 (Day) 1856 (Year)

8. AGE: Years 89 Months 1 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business housekeeping

12. Name W. Smith

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

14. Maiden name Koover

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

16. (a) Informant J. W. Mount

(b) Address 3817 Benton Blvd. K.C. Mo

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

(c) Place: burial or cremation Forest Hill Cemetery

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

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

19. (a) 10-17-45 (b) Gertrude Holmes
(Date received local registrar) (Registrar's signature)

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. 3817 Benton Blvd. 8
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15 year 1945 hour 12:30 minute A. M.

21. I hereby certify that I attended the deceased from Oct 15 1945 to Oct 15 1945
that I last saw her alive on Oct 15, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration _____

Due to Arterio Sclerosis 10 yrs

Due to Hypertension

Other conditions (include pregnancy within 3 months of death) _____

Major findings: no 830

Of operations _____

Of autopsy no

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) _____ (e) Means of injury _____

23. Mrs Caspell (M. D. or other) _____

Address 4600 Bellman _____

Pr
4000 Baltimore
Va 5115

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. M. Plank

Licensed Embalmer No. 1848

P. O. Address T.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.