

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36389

State File No. _____
Registrar's No. **4565**

FILED NOV 26 1945

Registration District No. _____ Primary Registration District No. **1002**

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:
617 North Brooklyn
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community **64 Yrs**
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")

(d) Street No. **617 North Brooklyn** **8**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **Mary A. Shrock**

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 **Married**

6. (b) Name of husband or wife **Ira D. Shrock** 6. (c) Age of husband or wife if alive **66** years

7. Birth date of deceased **Feb 22 1881**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **3**
year **1945** hour **2:30** minute **A** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

64	8	11	hr. _____ min.
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Immediate cause of death **Cerebral thrombosis**

Due to **atherosclerosis**

Due to _____

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

9. Birthplace **Kansas City Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **Daniel Cahill**

13. Birthplace **No record** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Minor**

15. Birthplace **No record** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ira D Shrock**

(b) Address **617 North Brooklyn**

17. (a) **Burial** (b) Date thereof **Nov 6 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Cem.**

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

(b) Address **918 Brooklyn**

19. (a) **11-5-45** (b) **M. E. Holmes**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations **94a**

Of autopsy **no**

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 _____

23. Signature **Jane C. Walker** (M. D. or other) **Walker**

Address **1424 1/2 of 1st** Date signed **11-3-45**

(Licensed Embalmer's Statement on Reverse Side)

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

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

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.

H.C. Mo.