

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

13273

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1685

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:
St. Joseph Hospital ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether _____)

In this community 22 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 9300 Wilson Road
(If rural, give location)

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

3. (a) PRINT FULL NAME ERMA MARIE MCDONALD MAYNARD

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

3. (c) Social Security No. none
496-05-9683

4. Sex Female / 5. Color or race Wh.

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

6. (b) Name of husband or wife Arthur S. Maynard

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased June 2 1905
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>10</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Frank McDonald

13. Birthplace Lawrance Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Ida Zook

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

16. (a) Informant Arthur S. Maynard

(b) Address 9300 Wilson Road K. C. Mo

17. (a) Burial (b) Date thereof April 10, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Wilks Funeral Home

(b) Address 2315 Linwood K. C. Mo.

19. (a) 4-9-46 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 8
year 1946 hour 11 minute 5 a.m.

I hereby certify that I attended the deceased from 3
18, 1946 to 19;
that I last saw him alive on 4/8/46 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction Duration 3 hrs.

Due to Carcinoma of left broad ligament

Due to metast. Duration 3 yr.

Other conditions 492
(Include pregnancy within 3 months of death)

Major findings: Resection of
Of operations left broad ligament
Cyst carcinoma
Of autopsy _____

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 _____

Where did injury occur? _____
(City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____

23. Signature Erma Marie Maynard (M. D. _____)

Address 4153 94th Date signed 4/8/46

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

121179

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 *Chas. J. Wilks*.....

Licensed Embalmer No. *2644*.....

P. O. Address *Honolulu, Oahu, 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.