

S. No. 2  
M-5-43  
5-17-39  
I X36871

**FILED** MAY 27 1948  
Registration District No. 149

Primary Registration District No. 1002

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

15625

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:  
1224 Washington  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 13 years years, months or days)

3. (a) PRINT FULL NAME MABELLE FREEMAN MCCOY

3. (b) If veteran, name war NO

3. (c) Social Security No. 500-01-5433

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Chauncy M. McCoy

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased July 8 1879  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>10</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Kitchen worker

11. Industry or business K. C. Club

12. Name Unknown, Plant

13. Birthplace Unknown  
(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 Samuel C. Farley

(b) Address 1224 Washington

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-15-46  
(Month) (Day) (Year)

(c) Place: burial or cremation Joplin, Missouri

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

(b) Address 2315 Linwood K. C. Mo

19. (a) 5-14-46 (Date received local registrar) (b) Steraldine Holmes (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. 1224 Washington  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 10  
year 1946 hour 7:10 minute 0 M.

21. I hereby certify that I attended the deceased from before 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Artery aneurism

Due to Artery aneurism

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 9/4a

Major findings:  
Of operations \_\_\_\_\_

Of autopsy yes as above

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 fall

23. Signature Jamie Walker (M.D. or other) \_\_\_\_\_  
Address 1224 Washington Date signed 5-11-46

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**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 E. Wilks  
.....  
- Licensed Embalmer No. 2644  
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.**