

FILED MAY 20 1946

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2082

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:
Chase Hotel, 912 Holmes St. /
 (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 6 months
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 47
 (c) City or town Kansas City 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. Chase Hotel, 912 Holmes St. 8
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.

3. (a) PRINT FULL NAME

Mrs. Mary Elizabeth Mather

3. (b) If veteran,
name war No3. (c) Social Security
306 20 6226

4. Sex female / 5. Color or race white
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife Clay Buell
 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased October 12 1924
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>6</u>	<u>26</u>	hr. min.

9. Birthplace North Manchester Indiana
 (City, town, or county) (State or foreign country)

10. Usual occupation Clerk11. Industry or business Katz Drugs12. Name Harold Mather13. Birthplace unknown 9
(City, town, or county) (State or foreign country)14. Maiden name unknown 115. Birthplace unknown 9
(City, town, or county) (State or foreign country)16. (a) Informant Mr. Clay Buell(b) Address 912 Holmes St., K. C., Mo.17. (a) Removal (b) Date thereof 5/8/46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Wabash, Indiana18. (a) Signature of funeral director Melody-McGilley-Eyler(b) Address 1800 Linwood Blvd. K.C., Mo.19. (a) 5-8-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
 year 1946 hour 2:05 minute AM M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____,
 and that death occurred _____ the date and hour stated above.

Immediate cause of death Deputy Coroner Duration

Cause of death

Due to unknown

Due to pending

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

Major findings: _____

Of operations _____

Of autopsy See Above

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 job)

(e) Manner of injury See Above

23. Signature A.E. Mather (M. D. or R. N.)

Address 2800 Main Date 5/8/46

JUL 23 1945

MAY 13 1946

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 2082

Registration District No. 149

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: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 6 months
years, months or days

3. (a) PRINT FULL NAME

Mrs. Mary E. Mather

3. (b) If veteran, name war. no 3. (c) Social Security No. 306-20-6226

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 12 (Month) (Day) (Year)

8. AGE: Years 21 Months _____ Days _____ (If less than one day) hr. _____ min.

9. Birthplace North Manchester, Ind (City, town or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business Retail Drug Store

12. Name: Marold Mather

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 Mr. Clay Buell

(b) Address 912 Holmes St., K C Mo

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Melody-McGilley-Eylar

(b) Address 1800 Linwood Blvd K.C.Mo

19. (a) 5-8-40 (b) Sheraldine 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. Chase Hotel, 912 Holmes St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____

that I last saw him alive on _____ and that death occurred on the _____ and about stated above. Immediate cause of death Shock

Due to Hemorrhage

Due to Abortion, incomplete -

Other conditions Cause unknown -
(Include pregnancy within 3 months of death)

Major findings: Of operations 1416

Of autopsy See Above

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) (b) Means of injury _____

23. Signature A. E. Usher (M. D. or other) MD
Address 7800 / main Date signed 7/10/40

SUPPLEMENTARY

5638

JUL 23 1945

10756

RECEIVED
JUL 23 1945