

S. No. 2
 FORM-5-43
 Rev. 5-17-39
 I X38671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

23601
 3210

State File No. _____
 Registrar's No. _____

FILED AUG 5 1946

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days
(Specify whether
 In this community 35 YEARS
years, months or days)

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. 3102 E. 19 Terr.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Dorothy E Gaffin
 (b) If veteran, name war No
 (c) Social Security No. NONE

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 22
 year 1946 hour 8 minute 20 A.M.
 21. I hereby certify that I attended the deceased from
July 18, 1946 to July 22, 1946
 that I last saw her alive on July 22, 1946
 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife MR. FRANK W. GAFFIN
 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased JANUARY 8 1887
(Month) (Day) (Year)

Immediate cause of death Subarachnoid hemorrhage
 Due to _____
 Due to _____
 Other conditions 83 m
(Include pregnancy within 3 months of death)

8. AGE: Years 59 Months 6 Days 14
 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____
 12. Name GEORGE M. SMITH
 13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)
 14. Maiden name SUSANNA JOHNS
 15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy See above
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant MR. FRANK W. GAFFIN
 (b) Address 3102 EAST-19TH STREET TERR.
 17. (a) BURIAL (b) Date thereof JULY 25 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation MEMORIAL PARK CEM.

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? _____

18. (a) Signature of funeral director D. W. Newcomer, Sr.
 (b) Address 1401 BRUSH CREEK BLVD
 19. (a) 7-24-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature John W. Hart (M. D. or other) MD
Med. Dir. Gen'l Hosp.
 Address _____ Date signed 7-25-46

(Licensed Embalmer's Statement on Reverse Side)

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

22457

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 Emile M. Calhoun

Licensed Embalmer No. 3506

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.