

S. No. 2  
DM-2-43  
v. 5-17-39  
P-1 X35597

4981

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAR 10 1947  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 934

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

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: Research Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution since 2-25-47  
In this community 5 Days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Josephine Ann Montgomery  
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 F. C. Montgomery  
6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased 9 18 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 11 13 hr. min.

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

10. Usual occupation at home

11. Industry or business X

12. Name Milton Rier  
13. Birthplace Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Geenie  
15. Birthplace New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Cecil O. W. Johnson

(b) Address Quinter, Kans

17. (a) removal (b) Date thereof 3-1-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quinter, Kansas

18. (a) Signature of funeral director Stire & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 3-1-47 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kansas (b) County 934  
(c) City or town Quinter  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 1  
year 1947 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from 2-24-47, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on 2-28-47, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Thrombosis - Emboli  
Due to Coronary Thrombosis

Due to mitral stenosis

Other conditions Obesity  
(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 place)  
(e) Means of injury MI  
Signature Paul Jackson (M. D. or other) MD  
Address 424 P. 1307 K.C. Mo. Date signed 3-1-47

*Prof. Black*

*Dr. Black*

FEB 1 1949

Dr. Black

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 *J. Allen*

Licensed Embalmer No. *1415*

P. O. Address *150 W. 10th St.*

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.