

S. No. 2  
1-12-45  
v. 5-17-39  
I X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 21 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9279

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

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 987

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. 13 hrs.  
(Specify whether in this community years, months or days)

25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 2035 Cypress 8  
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Etta Monroe

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Frank L. Monroe

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased July 10 1870  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2  
year 1947 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 1 19 47 to March 2 19 47  
that I last saw her alive on March 2 19 47  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>7<del>2</del></u>	<u>22</u>	hr. _____ min.

Immediate cause of death Carcinoma of breast with metastasis to lung

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

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

Other conditions 50  
(Include pregnancy within 3 months of death)

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

Of autopsy See above

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Sam Druery

13. Birthplace Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Milissa Thompson

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

16. (a) Informant Frank L. Monroe

(b) Address 2035 Cypress Ave.

17. (a) Cremation (b) Date thereof 3/4/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Earp & Sons

(b) Address 4139 East 15th. St.

19. (a) 3-4-47 (b) Shiraldine Holmes  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

23. Signature W. W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 3-3-47

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

*Dr. H. K. ...  
Dr. K. ...*

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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.....

*John B. ...*

Licensed Embalmer No. *9555-*

P. O. Address *18 C. ...*

**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.**