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-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9516**  
Registrar's No. **1308**

FILED APR 1 1947

Registration District No. **197**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: General Hospital No. 1  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 5 days  
(Specify whether in this community \_\_\_\_\_ years, months or days)

In this community 76 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret YOUNG WORTH

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 Anthony J. Youngworth

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased April 16, 1870  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>2</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business At home

12. Name John Cunningham

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

14. Maiden name Ann Kelly

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

16. (a) Informant Mr. J. J. Youngworth

(b) Address 3929 Wabash Ave., K. C., Mo.

17. (a) Burial (b) Date thereof 3-21-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

(b) Address Kansas City, Mo.

19. (a) 3-20-47 (b) Marjoline Holme  
(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. 208 W. 81 Terr.  
(If rural, give location)

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19  
year 1947 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 14, 1947 to March 19, 1947, that I last saw her alive on March 19, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident  
Diabetes mellitus

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

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

Other conditions W.I.  
(Include pregnancy within 3 months of death)

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

Of autopsy None

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 Wm. W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 3-19-47

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

FEB 20 1948

*Dr. Taylor*

**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.....

.....  
working under my personal supervision.

..... Registered Apprentice No. ....

Signature

*J. Taylor*

..... Licensed Embalmer No. ....

..... P. O. Address .....

**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.