

No. 2
M-5-43
v. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20856**
Registrar's No. **2705**

FILED JUL 3 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 Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1226 1/2 Campbell
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 10 yrs
years, months or days)

3. (a) PRINT FULL NAME Effie Canfield
 3. (b) If veteran, name war No
 3. (c) Social Security No. none

4. Sex Femal / 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife unknown Canfield
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Feb 1 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 18
If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER {
 12. Name Williams
 13. Birthplace No Record
(City, town, or county) (State or foreign country)
 14. Maiden name No record
 15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lola Vasquez (Friend)

(b) Address 1226 1/2 Campbell

17. (a) Burial (b) Date thereof June 24 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs C. L. Forster

(b) Address 918 Brooklyn

19. (a) 6-24-47 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson #8
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 1226 1/2 Campbell 1
(If rural, give location)
 (e) Citizen of foreign country? no 0
(Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day # 19
 year 1947 hour _____ minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis
 Due to _____

Due to Reputy Coronar
 Other conditions History 93rd
(Include pregnancy within _____ months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy History 93rd
 Underline the cause to which death should be charged statistically.

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) (Date and time of injury)
 Signature W. J. ... (M. P. No. _____)
 Address 2800 Main Date 6/24/47

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..... *Orland Munro*

Licensed Embalmer No. *3474*

P. O. Address..... *918 Broad 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.