

S. No. 2
 JM-5-43
 v. 5-17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **20961**
 Registrar's No. **2402**

FILED JUN 17 1947

Registration District No. **1947** 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
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2311 Agnes
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community About 5 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. 2311 Agnes
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mary Frances Glass
 3. (b) If veteran, name war no 3. (c) Social Security No. None
 4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Ben Glass
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May - 4 - 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 30
 year 1947 hour 5:40 minute _____ M.
 21. I hereby certify that I attended the deceased from May 30, 1947 to May 30, 1947
 that I last saw her alive on May 30, 1947
 and that death occurred on the date and hour stated above.
 Duration _____
 Immediate cause of death _____

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>0</u>	<u>26</u>	_____ hr. _____ min.

Acute Dilatation of Heart
 Due to _____
 Due to _____

9. Birthplace Osage Co., Kansas
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: 950
 Of operations _____
 Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business
 12. Name John Benning
 13. Birthplace Ky.
(City, town, or county) (State or foreign country)
 14. Maiden name Angelina Mosby
 15. Birthplace Platte Co., Mo.
(City, town, or county) (State or foreign country)

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) (Means of injury)

16. (a) Informant Sarah Williams
 (b) Address 2200 Grandview, Kansas City, Mo.
 17. (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lincoln Cemetery
 18. (a) Signature of funeral director E. Sterling Bills
 (b) Address 1212 Vine St., Kansas City, Mo.
 19. (a) 6-3-47 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature Lucian P. Richardson M.D.
(Physician's name)
 Address 1801 - Vine Date signed 5-30-47

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 *E. Sterling Bille*.....

Licensed Embalmer No..... 3178.....

P. O. Address 1212 Vine St., Kansas Ci

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.