S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24303
Registrar's No. 2961

Registration District No. 149 Primary Registration District No. 1002

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 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ~~no~~ 1 hr (Specify whether
In this community 22 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 47
(c) City or town KansasCity 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2510 Bellfountain 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Mrs. Mary Catherine Mommertz
3. (b) If veteran, name war no
3. (c) Social Security No. 500-28-3429
4. Sex Fem
5. Color or race Wh
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife William Mommertz
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased 4/3/1886 (Month) (Day) (Year)

8. AGE: Years 61 ~~59~~ Months 3 Days 8 If less than one day hr. min.

9. Birthplace ~~Iowa~~ Unk. (City, town, or county) Iowa 1 (State or foreign country)
10. Usual occupation Clerk
11. Industry or business Myron Green Caffateria
FATHER
12. Name Charles B; Boyer
13. Birthplace Unk (City, town, or county) Unk 9 (State or foreign country)
MOTHER
14. Maiden name Mary Sherridan
15. Birthplace Unk (City, town, or county) Unk 0 (State or foreign country)
16. (a) Informant Wm. Mommertz 1
(b) Address 2510 Bellfountain
17. (a) B urial (Burial, cremation, or removal) (b) Date thereof 7-14-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery
18. (a) Signature of funeral director John P. Sheil
(b) Address Kansas City, Mo.
19. (a) 7-12-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 11
year 1947 hour 8 35 minute a M.
21. I hereby certify that I attended the deceased from Corona, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage & spasm of glottis & vocal cords.	
Due to Congestion of lungs	
Due to Heart failure. (hit by man's fist)	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 168	
Of autopsy yes as above	

PHYSICIAN
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) Homicide
(b) Date of occurrence 7-11-47
(c) Where did injury occur? Kc. Jackson mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)
While at work? no (e) Means of injury Trauma
23. Signature James C Walker (M. D. ~~or other~~) Corona 3
Address 1429 Prof Bldg Date signed 7-11-47

(Licensed Embalmer's Statement on Reverse Side)

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 P Shiel

Licensed Embalmer No. 3625

P. O. Address 16 6 Ins

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.