

No. 2
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-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 24 1947
Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38312
Registrar's No. 4781

Primary Registration District No. 1002

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:
Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 50 yrs - (Specify whether years, months or days)

3. (a) PRINT FULL NAME Marcum, Mrs Maggie
3. (b) If veteran, name war no 3. (c) Social Security No. no.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Mr. Bennie Leroy Marcum 6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 27 1882
(Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 18 If less than one day hr. 72 min. 70

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

10. Usual occupation Housewife

11. Industry or business

12. Name J. B. Mason
13. Birthplace Springfield Mo. (City, town, or county) (State or foreign country)
14. Maiden name Ed Liza P. Richardson
15. Birthplace Fayetteville Ark (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mabel Stewart
(b) Address 1609 - E - 39 st

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-15-47 (Month) (Day) (Year)
(c) Place: burial or cremation Walnut Grove Mo

18. (a) Signature of funeral director Mrs C. P. Foster
(b) Address 918 Brooklyn

19. (a) 11-15-47 (Date received local registrar) (b) Theraldine Holmes (Registrar's signature)

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. 1609 E. 39th 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15 year 1947 hour 12 minute 40 M.

21. I hereby certify that I attended the deceased from Nov. 8th 1947, to Nov. 15 1947 that I last saw her alive on Nov. 15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to Hypertension

Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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 0
23. Signature G. Juarez-Rena (M. D. or other MD.)
Address 1612 Proj. Bldg. Date signed 11-15-47

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

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

MOTHER FATHER

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..... *Cortland Minor*

Licensed Embalmer No. *3414*

P. O. Address. *918 Brooklyn*

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.