

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **149**

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 1/2 hrs.
(Specify whether years, months or days)

In this community 45 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County JACKSON **48**

(c) City or town K.C. **3**
(If outside city or town limits, write "RURAL")

(d) Street No. 8100 WORNALL RD **8**
(If rural, give location)

(e) Citizen of foreign country? NO **0**
(Yes or No)

If yes, name country _____

3: (a) PRINT FULL NAME Margaret Andrews

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 W. DOW

6. (b) Name of husband or wife WM BRUCE ANDREWS 6. (c) Age of husband or wife if alive DEC 2 years

7. Birth date of deceased JAN 17 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>7</u>	<u>7</u>	hr. _____ min. _____

9. Birthplace PENN. **1**
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER

12. Name JACOB SMITH BARNHAR

13. Birthplace PA. **1**
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET DURST

15. Birthplace PA. **1**
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. E. E. MATTOCKS

(b) Address 8100 WORNALL RD

17. (a) BURIAL (b) Date thereof 8 28 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT WASHINGTON

18. (a) Signature of funeral director STANLEY MCCURE

(b) Address K.C. MO

19. (a) 8-28-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26
year 1948 hour 12 minute 45 P. M.

21. I hereby certify that I attended the deceased from Aug. 25, 1948 to Aug. 26, 1948; that I last saw her alive on Aug. 26, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Acute pulmonary embolism

Due to thrombosis of the left iliac vein

Due to _____

Other conditions 111a
(Include pregnancy within 3 months of death)

Major findings: See above

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)

(c) Means of injury _____

23. Signature Geraldine Holmes (M.D. or other)
Address Med. Dir. Gen'l Hosp. **8-21-48**
Date signed

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. P. H. ...

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 *Robert H. Reed*.....

Licensed Embalmer No. *3745*.....

P. O. Address *K. C. Mo.*.....

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.