

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 5284  
Registrar's No. \_\_\_\_\_

40183

FILED JAN 15 1948  
Registration District No. \_\_\_\_\_

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: 4809 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 28 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. 4809 Campbell  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Mary Ann Hoyle  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 26th.  
year 1948 hour 11:00 minute \_\_\_\_\_ P. M.

4. Sex Female / 5. Color or race White  
6. (a) Single, widowed, married, divorced / Married  
6. (b) Name of husband or wife James Hoyle  
6. (c) Age of husband or wife if alive 74  
7. Birth date of deceased September 24th. 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 21, 1948, to Dec 26, 1948  
that I last saw him alive on December 25, 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
81 3 2 hr. \_\_\_\_\_ min.

Immediate cause of death cerebral Hemorrhage  
Due to Hypertensive Cardio-Vascular Heart Disease 3 yrs.  
Due to \_\_\_\_\_

9. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)  
10. Usual occupation At Home

Other conditions (Include pregnancy within 3 months of death)  
Major findings: 930  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Henry Moyer  
13. Birthplace Don't Know  
(City, town, or county) (State or foreign country)  
14. Maiden name Don't Know  
15. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

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

16. (a) Informant James Hoyle  
(b) Address 4809 Campbell  
17. (a) Removal (b) Date thereof 12-28-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Gibson City, Illinois  
18. (a) Signature of funeral director Freeman Mortuary  
(b) Address Kansas City, Missouri  
19. (a) 12-28-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

Blaine Z. Hibbard (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature Blaine Z. Hibbard (M. D. or other) MD  
Address 411 Glendale Rd. Date signed Dec 27 1948

411-  
V-430

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**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 *Willis H. Bennett*

Licensed Embalmer No. *4438*

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.**