

FILED MAY 27 1949

STANDARD CERTIFICATE OF DEATH

15935

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2112

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (If this place) Life		d. STREET ADDRESS (If rural, give location) 4000 Washington	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4000 Washington			

3. NAME OF DECEASED (Type or Print) Mary			a. (First)		b. (Middle)		c. (Last) Howard		4. DATE OF DEATH (Month) (Day) (Year) 5-14-49				
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) widowed			8. DATE OF BIRTH 5-26-1879		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 60 MIN. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Illinois			12. CITIZEN OF WHAT COUNTRY? U. S. A.		

13a. FATHER'S NAME T. C. Rice			13b. MOTHER'S MAIDEN NAME Mary A. Long			14. NAME OF HUSBAND OR WIFE Frank Howard		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME Mrs. Colvin B. Wilkins				ADDRESS 3338 Wabash	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic glomerulonephritis							
		ANTECEDENT CAUSES							
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 592x							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE OF REGISTRAR E.C.H. Schmidt		23b. ADDRESS St. Luke's Hospital		23c. DATE SIGNED 14/5/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-16-49		24c. NAME OF CEMETERY OR CREMATORY Forest Hill		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
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DATE REC'D BY LOCAL REG. 5-14-49		REGISTRAR'S SIGNATURE Sheraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE		ADDRESS Kansas City, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

~~R. J. Proctor~~
Phys. med.
Dr. Schmidt
Posting

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Max C. Meyer

Signed _____
Student Embalmer

Licensed Embalmer No. _____

4555

P. O. Address _____

Kansas City, 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.