

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41204

State File No. ....

5357

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>GENERAL HOSPITAL #2</b>		d. STREET ADDRESS (If rural, give location) <b>1317 TROOST APT. 215</b>	

3. NAME OF DECEASED (Type or Print): <b>MARGARET</b>	a. (First)	b. (Middle)	c. (Last) <b>McCURRY</b>	4. DATE OF DEATH <b>DECEMBER 17 1949</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 19, 1882</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	IF UNDER 15 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>TROY, KANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
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13a. FATHER'S NAME <b>ALEC WILKINSON</b>	13b. MOTHER'S MAIDEN NAME <b>CORA SMITH</b>	14. NAME OF HUSBAND OR WIFE <b>MATTHEW ALLEN McCURRY</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>-- NO.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MINTA WILKINSON, 1317 TROOST</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL HEMORRHAGE</b>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 12/16/, 1949, to 12/17, 1949, that I last saw the deceased alive on 12/17, 1949, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE <i>Frank Ellis</i> (Degree or title) <b>Frank Ellis, M.D.</b>	23b. ADDRESS <b>600 E. 22d</b>	23c. DATE SIGNED <b>12/17/49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12/17/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>-</b>	24d. LOCATION (City, town, or county) (State) <b>Troy, Kansas</b>
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DATE REC'D BY LOCAL REG. <b>12-17-49</b>	REGISTRAR'S SIGNATURE <i>Geraldine Holmes</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Alexander</i>	ADDRESS <b>St. Joe, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.

Student .....  
Student Embalmer

Signed..... *Wm H Alexander*

Licensed Embalmer No. *4450*

P. O. Address *St. Joseph, 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.