DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27647

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2021

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

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:
Wesley Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One hour (Specify whether years, months or days)
In this community 19 Years in K C K

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

(c) City or town Kansas City Kansas
(If outside city or town limits write "RURAL")

(d) Street No. 1247 Metropolitan Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

Marion Lorraine McCurdy

3. (a) PRINT FULL NAME MARION LORRAINE McCURDY

3. (b) If veteran, name war —

3. (c) Social Security No. 26-

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased April 6 1921 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	19	4	10	____ hr. ____ min.

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

10. Usual occupation None

11. Industry or business at home

MOTHER FATHER

12. Name Willis J McCurdy

13. Birthplace Cincinnati (City, town, or county) Ohio (State or foreign country)

14. Maiden name Alice Servos

15. Birthplace Ft. Scott (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Willis J. McCurdy

(b) Address 1247 Metropolitan K C K

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill Cemet

18. (a) Signature of funeral director Simmons Funeral Home

(b) Address Kansas City Kansas

19. (a) Aug. 19, 1940 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ____ day 8-16-40
year ____ hour about 5 00 P. minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__;
that I last saw ____ alive on ____, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Acute septicemia	
Due to (type not determined)	
Other conditions (Include pregnancy within 3 months of death)	

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

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? (Specify)

While at work? (e) Means of injury

23. Signature Orlo H Fuller (M. D. or other)

Address K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27647

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 3281

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: Wesley Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ In this community ____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town Kansas City Kans
(If outside city or town limits write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Marion Lorraine McCurdy

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex F 5. Color or race Wh 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ____ 6. (c) Age of husband, or wife, if alive ____ years

7. Birth date of deceased ____ (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
19	4	10	____ hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

MOTHER / FATHER

12. Name ____

13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER

14. Maiden name ____

15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____

(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)

(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____

(b) Address ____

19. (a) 8/19/40 (Date received by local registrar) (b) M. M. Browne (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16
year 1940 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Acute septicemia	
Due to Chronic pelvic inflammatory disease (etiology & organism not known)	
Other conditions (Include pregnancy within 3 months of death) 139.0	

Major findings:
Of operations ____

Of autopsy ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide? Do not know

(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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other)

Address K. C. Mo ____ Date signed ____

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