REC'D APR 17 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9447
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 2 Registration District No. 399
(b) Township Raw Primary Registration District No. 1002 Registered No. 1053
or
(c) City Kans City 1 (d) Street No. 619 E. 9th St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 450 Hannah Josephine Nylan
(a) Residence, No. 619 East 9th St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe
4. COLOR OR RACE Wh
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 12-1882

7. AGE YEARS 55 MONTHS 8 DAYS 24 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Seamstress
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vermillion South Dakota

FATHER
13. NAME Erick Nylan
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

MOTHER
15. MAIDEN NAME Christine Johnson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

17. INFORMANT (ADDRESS) Mrs Florence Anderson 1024 Turner Blvd. Omaha Nebr

18. BURIAL, CREMATION, OR REMOVAL
PLACE Vermillion, So Dakota DATE 3/8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Carroll-Davidson 3024 Troost

20. FILED Mch 8 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-6-39, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....
I last saw h.... alive on ....., 19.... Death is said to have occurred on the date stated above, at 11:30 a.m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Carbon monoxide poisoning

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Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide Suicide Date of injury 3-6-39
Where did injury occur? K.C. Mo (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Found in hotel room
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Orestor Hunter, M.D.
(Address) Gen Hosp; K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

Licensed Embalmer No.....

P. O. Address.....

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

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