

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4176

1. PLACE OF DEATH:

(a) County Jackson **NOV 14 1939**

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: H. C. Gen. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

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

(d) Street No. 3420 Troost
(If rural, give location)

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

8. (a) PRINT FULL NAME Elizabeth Kelley

8. (b) If veteran, name war. no

8. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1939 hour 9 minute 10-9 M.

21. I hereby certify that I attended the deceased from Oct 21 - 31, 1939, to Oct 31 - 31, 1939
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased: June 10 1876
(Month) (Day) (Year)

Immediate cause of death Right frontal encephalomalacia Duration _____

Due to Subarachnoid hemorrhage

Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

8. AGE: Years 62 Months 4 Days 27 If less than one day _____ hr. _____ min.

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

Major findings: Of operations _____

Of autopsy See above

PHYSICIAN _____
Underline the cause to which death should be charged statistically

10. Usual occupation at home

11. Industry or business F

MOTHER FATHER

12. Name Francis J. Hara

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

14. Maiden name Unknown

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

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? _____

16. (a) Informant's own signature Record Clerk

(b) Address H. C. Gen. Hosp.

17. (a) Burial (b) Date thereof 11-1-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director M. M. Crowley

(b) Address H. C. Gen. Hosp.

19. (a) 10/31/39 (b) M. M. Crowley
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. J. E. Moran M.D. (M. D. or other) _____
H. C. Gen. Hosp. Date signed 10-31-39

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

Rev. 5-17-39
U. S. G. P. 1 X1931

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.

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 with the above constitutes grounds for revocation of license.)

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