

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

REV. 6-17-39
FORM 1 X39511

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5463

State File No. _____

688

Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 22 days
(Specify whether
Life
years, months or days)

3. (a) PRINT FULL NAME LYNNA ELIAS

8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alvin B. Elias 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Feb. 27th 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 11 Days 17 If less than one day hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name L L Eason

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

14. Maiden name Lillie Mae Alford

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

16. (a) Informant's own signature A. B. Elias

(b) Address 4029 McGee St., K. C. Mo.

17. (a) Removal (b) Date thereof 2/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Platte Nebr.

18. (a) Signature of funeral director Melody-McGilley.

(b) Address K. C. Mo.

19. (a) Feb. 15, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 4029 McGee
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14th
 year 1940 hour 11 minute 55 P. M.

21. I hereby certify that I attended the deceased from 1-23-40, 19____, to 2-14-40, 19____;
 that I last saw h. er alive on 2-14-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Post operative hysterectomy

Due to Adenocarcinoma of uterus

Due to _____

Other conditions 41
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy None

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? _____

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

23. Signature E. J. DeMara M.D. (M. D. or other)

Supt. K. C. Gen. Hospital 2-15-40
Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.