

FILED MAR 11 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days) 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 137 Colorado  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME Elizabeth Jane Prose

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Clarence Prose 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Nov 2 1894  
(Month) (Day) (Year)

8. AGE: Years 45 Months 9 Days 12  
If less than one day hr. min.

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

10. Usual occupation Homemaker

11. Industry or business At Home

12. Name John R. Colran  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Dora Reid  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clarence Prose  
(b) Address 137 Colorado, K.C., Mo.

17. (a) Burial (b) Date thereof Feb. 16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Leasburg, Mo.

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.  
(b) Address 2825 Indep. Blvd. K.C., Mo.

19. (a) Feb 16-40 (b) Mimbrow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Sept 1  
1939 to Feb 14 1940.  
that I last saw her alive on Feb 14 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis  
Due to Rheumatic fever  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations None  
Of autopsy yes

Duration 5 years  
8 years ago  
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 (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 Charles Nelson (M. D. or other) \_\_\_\_\_  
Address 3626 Andy ave Date signed 2-16-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.....

*B. H. Blackman*

Licensed Embalmer No. *2244*

P. O. Address *K. C. 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, above space should be left blank.**