V. S. No. 2
OM—11-10-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9539

Registration District No. 399 FEB APR 12 1940

Primary Registration District No. 1002

Registrar's No. 973

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:
1815 East 7 th St. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo. 8
(If outside city or town limits write "RURAL")

(d) Street No. 1815 East 7 th St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Elizebeth Whitlock 342

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Femal

5. Color or race White

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

6. (b) Name of husband or wife JosephWhitlock

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

7. Birth date of deceased May 19 1848 (Month) (Day) (Year)

8. AGE: Years 91 Months 9 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Iowa (State or foreign country) 1

10. Usual occupation None

11. Industry or business _____

FATHER
12. Name Samuel Gatton 9
13. Birthplace _____ (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Elizebeth Daniels
15. Birthplace _____ (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant Rubye S.Skeels
(b) Address 1815 East 7 St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 2 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hill Cem.

18. (a) Signature of funeral director Mrs C.L.Forster
(b) Address 918 Brooklyn Kansas City Mo.

19. (a) Mch 1, 1940 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 29
year 1940 hour 9 minute 25 A M.

21. I hereby certify that I attended the deceased from Indefinite, 19__, to Feb. 29th 1940, 19__;
that I last saw her alive on Feb. 27th, 1940, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility and terminal bronchopneumonia	
Due to 10 Ca	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy None	

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? _____ (Specify type of place)
While at work? _____ (e) Means of injury 1

23. Signature P. J. DeMaria M.D. (M. D. or other)
Supt. K.C. Gen. Hospital, K.C. Mo.
Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

Gen Hosp Dr.

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 me, Registered Apprentice No. , working under my personal supervision.

Signed Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Ft. Oma

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.