

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9901
1335

State File No. _____

Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3543 Flora
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
50 Yrs (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL")
 (d) Street No 3543 Flora Avenue, K.C. Mo.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Ellen Helden, L35

3. (b) If veteran, name war No
 3. (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 Alfred H. Helden,
 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Jan. 2nd, 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>2</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Abraham Serridge,
 13. Birthplace England
(City, town, or county) (State or foreign country)

{ 14. Maiden name Ellen Serridge,
 15. Birthplace England
(City, town, or county) (State or foreign country)

16. (a) Informant Alfred H. Helden,
 (b) Address 3543 Flora Avenue, K.C. Mo.

17. (a) Burial (b) Date thereof Mch. 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, K.C. Mo.

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.
 (b) Address 28251 Indep. Blvd., K.C. Mo.

19. (a) Mch 26, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25th, 1940
 year 1940 hour _____ minute 5.55 P.M.

21. I hereby certify that I attended the deceased from Jan 1-40
 _____, 19 _____, to Mar 25, 1940
 that I last saw him alive on Mar 25, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Pneumonia
Cerebral Hemorrhage
Old age + arterio sclerosis

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration

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 [Signature] (M. D. or other)
 Address 311 Argyle 1909 Date signed 3/26-40

Dr. Rumsey,
Office Altoona, Pa.
Phone WAD 15079

12-5130

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.