

MAY 15 1940

399

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1002

State File No. **13971**

Registrar's No. **1683**

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
2711 East 12th. St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 5 Months  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Michigan (b) County J  
(c) City or town Grand Rapids  
(If outside city or town limit- write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Carrie B. Hatch 321

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

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 3 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>1</u>	<u>19</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Daniel Eckenroad  
13. Birthplace Penn.  
(City, town, or county) (State or foreign country)

14. Maiden name Lovina Austin  
15. Birthplace New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Ella J. Cooper  
(b) Address 2711 East 12th. St.

17. (a) Removal (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Grand Rapids Michigan

18. (a) Signature of funeral director Mrs. L. S. Jester  
(b) Address \_\_\_\_\_

19. (a) 4-21-40 (b) M. M. Croome  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21  
year 1940 hour 1 minute 25 A.M.

21. I hereby certify that I attended the deceased from Jan 1, 1940, to April 20, 1940;  
that I last saw her alive on April 19, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic mitral regurgi.  
taken 1 mgo credits Duration \_\_\_\_\_

Due to focal infection 31

Due to \_\_\_\_\_

Other conditions Chronic interstitial nephritis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Harry W. Gray (M. D. or other)  
Address 1401 Proffert Date signed 4-21-40

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

CR. 8 347

14th. & Prospect

**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.....

*Theron A. Redman*

Licensed Embalmer No.....

2737

P. O. Address.....

A. O. M. D.

**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.**