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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 17 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42807

Registration District No. 400 Primary Registration District No. 5562 Registrar's No. 210

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Little Blue R. Prairie
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 89 days (Specify whether years, months or days)

In this community 4 years

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. 325 N. Home Fairmt. Sta
(If rural, give location)

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

3. (a) PRINT FULL NAME Olive Priest

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 Married

6. (b) Name of husband or wife Samuel Priest

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased October (Month) 23 (Day) 1903 (Year)

8. AGE: Years	Months	Days	If less than one day
37	1	11	hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own Home

MOTHER FATHER

12. Name Thomas Edmonds

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

14. Maiden name Katherine Fairholm

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

16. (a) Informant Samuel Priest

(b) Address 325 N. Home, Fairmt. Sta. MO

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-4-40 (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence, Kansas

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) 12-6-40 (Date received local registrar) (b) Lara G. Gaines (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4 year 1940 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from Sept. 6, 1940, to Dec. 4, 1940, that I last saw her alive on Dec 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. Kennedy (M. D. or other) M. D.

Address Jackson County Hospital Date signed 12/4/40

(Licensed Embalmer's Statement on Reverse Side)

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 Ralph E. Miller

Licensed Embalmer No. [illegible]

P. O. Address Endl., 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.