No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED MAR 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5761
533

Registration District No. 3199 Primary Registration District No. 1002 Registrar's No.

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

48
3
8

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community: No record

2. USUAL RESIDENCE OF DECEASED: 48
(a) State: Missouri (b) County: Jackson 3
(c) City or town: Kansas City (If outside city or town limits, write "RURAL") 8
(d) Street No.: 418 West 10th St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Ada Mary Boulton
3. (b) If veteran, name war: —
3. (c) Social Security No.:
4. Sex: F.
5. Color or race: W.
6. (a) Single, widowed, married, divorced: 9
6. (b) Name of husband or wife: No record
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: No record (Month) (Day) (Year)
8. AGE: Years: About 71 Months: No record Days: If less than one day: hr. min.
9. Birthplace: No record (City, town, or county) (State or foreign country) 6
10. Usual occupation: No record
11. Industry or business:
MOTHER FATHER
12. Name: No record
13. Birthplace: No record (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name: No record
15. Birthplace: No record (City, town, or county) (State or foreign country) 9
16. (a) Informant: Record clerk
(b) Address: K.C. General Hospital; K.C. Mo.
17. (a) Burial, cremation, or removal: State Asst Board (b) Date thereof: 2-7-41 (Month) (Day) (Year)
(c) Place: burial or cremation: K.C. Gen Hospt.
18. (a) Signature of funeral director: Wm. A. Johnson
(b) Address: K.C. Gen Hospt
19. (a) 2/6/41 (Date received local registrar) (b) M. M. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22nd year 1941 hour 3 minute 45 P. M.
21. I hereby certify that I attended the deceased from 1-17-41, 19__, to 1-22-41, 19__; that I last saw her alive on 1-22-41, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Right lower lobar pneumonia and Old Cerebral hemorrhage — Duration
Due to: 108
Due to:
Other conditions (Include pregnancy within 3 months of death): 15
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: 0
23. Signature: Henry R. Thom (M. D. or other)
Address: Med. Dir. K.C. Gen. Hospital, K.C. Mo. Date signed

(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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed; fact should be so stated above.

S. No. 2B
1—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 533

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:
(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)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Jackson
(c) City or town: Kansas City, Mo.
(If outside city or town limits write "RURAL")
(d) Street No.: 418 W. 10th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Ada Mary Boulton
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex .....
5. Color or race .....
6. (a) Single, widowed, married, divorced .....
6. (b) Name of husband or wife .....
6. (c) Age of husband, or wife, if alive ..... years
7. Birth date of deceased: Nov. (Month) 16 (Day) 1867 (Year)
8. AGE: Years 73 Months 2 Days 6 If less than one day ..... hr. ..... min.
9. Birthplace: Lower Swell Chellenham Eng. (City, town, or county) (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER 12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER 14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) 7/6/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22 year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? .....
While at work? ..... (Specify type of place) (e) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

S-5761