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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5783

RECEIVED MAR 14 1941
Registration District No. 349

Primary Registration District No. 1002

State File No. _____
Registrar's No. 555

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 4 days
In this community 30 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME NANCY Frances Heemsoth
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 Married
6. (b) Name of husband or wife William Heemsoth 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased May 10 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	8	27	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob Brunk
13. Birthplace No Record 9
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann
15. Birthplace No record 9
(City, town, or county) (State or foreign country)

16. (a) Informant William Heemsoth
(b) Address 2741 Troost

17. (a) Burial (b) Date thereof Feb 10 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

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

19. (a) Feb 8-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson 3
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 2741 Troost Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 7th
year 1941 hour 10 minute 55 A. M.
21. I hereby certify that I attended the deceased from 2-3-41, 19 , to 2-7-41, 19 ;
that I last saw her alive on 2-7-41, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial hemorrhage, left
Due to _____
Due to _____

Other conditions Bacculated aneurysm of aorta
(Include pregnancy within 3 months of death)
with mural thrombus attached.
Major findings: _____
Of operations _____
Of autopsy _____
See above

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)
(c) Means of injury _____
23. Signature Dwight R. Thom (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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 J. T. [Signature]

Licensed Embalmer No. 479

P. O. Address K. T. [Signature]

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

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
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nancy F. Hemsoth

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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 10 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 20
(If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: intracerebral hemorrhage, left;
sacculated aneurysm of aorta with
 mural thrombus (Syphilitic)
Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 Nancy R. Phone Ind. (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital 12-11-41

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

