

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH.

State File No. **9842**

APR 15 1941

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1251**

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12-17-40-3-25-41**
(Specify whether years, months or days)
In this community **40 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1009 E. 14th St.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **25**
year **41** hour **6** minute **35** A.M.
21. I hereby certify that I attended the deceased from
12-17- 19 **40** to **3-25-** 19 **41**
that I last saw her alive on **3-25-** 19 **41**
and that death occurred on the date and hour stated above.
Immediate cause of death
Hypertensive Type of Heart Disease

Due to **Acute Congestive Heart Failure**

Due to _____
Other conditions (include pregnancy within 3 months of death)
92H

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) (a) Means of injury **0**
23. Signature **R. P. Turner** (M. D. or other)
Address **Gen. Hosp. #2** Date signed **3-21-41**

3. (a) PRINT FULL NAME **Nellie Matthews**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **C. Matthews** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **7 28 1893**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 7 28 hr. min.

9. Birthplace **Ill. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown** **9**
(City, town, or county) (State or foreign country)

15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **General Hospital #2**

17. (a) **Tourmal** (b) Date thereof **3-29-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **W. of Summit**

18. (a) Signature of funeral director **W. W. Thoms**

(b) Address **1520 N. East, K. C. Mo.**

19. (a) **3/29/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 W. W. Thatcher Jr.

Licensed Embalmer No. 2700

P. O. Address 1520 N. 5th St. K.C.

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.