

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH

(a) County Lakewood

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Mary's
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks
(Specify whether weeks, months or days)

In this community 25 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lakewood

(c) City or town Kansas City
(If outside city or town limits, write "RURAL.")

(d) Street No. Newburn Hotel
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ELIZABETH DICKSON T. EARNLEY

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

4. Sex Female race white 5. Color or race _____

6. (a) Single, widowed, married, divorced, single

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

7. Birth date of deceased Mar 12 - 1888
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1941 hour 5 minute 20 p. M.

21. I hereby certify that I attended the deceased from April 1, 1941 to April 24, 1941
that I last saw her alive on April 24, 1941
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>1</u>	<u>12</u>	hr. _____ min. _____

Immediate cause of death Carcinoma of left ovary primary

Due to 49a

Due to Carcinoma of liver

Other conditions Generalized Carcinoma
(Include emergency within 6 months of death)

Major findings of operations as above

Of autopsy No

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Traffic Clerk

11. Industry or business Spain

12. Name Edna Earnley

13. Birthplace Harpers Ferry, W. Va.
(City, town, or county) (State or foreign country)

14. Maiden name May Gale

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

16. (a) Informant Thomas Oels

(b) Address St. Louis, Kansas

17. (a) Burial (b) Date thereof Apr 24 - 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director Wm. Stanton

(b) Address St. Mary's

19. (a) Apr 24 1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

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)

Means of injury 0

23. Signature M. M. Crow (M. D. or other) _____

Address 906 Grand News Date 4/24/41

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

5
RECEIVED
FEB 1 1967

EX-A
FEB 1 1967

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 with the above constitutes grounds for revocation of license.)

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

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1-40
422659

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 1626

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

NO PENAL RECORD

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
St. Mary's Hospital
(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

3. (a) PRINT FULL NAME Elizabeth Dickson Tearney

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex Female 5. Color or race White

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.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

53 1 12 min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER {

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 4/24/41

19. (a) 4/24/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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

20. DATE OF DEATH: Month April day 24th
year..... hour..... minute.....

21. I hereby certify that I attended the deceased from....., 19....., 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: Carcinoma of left lung (Primary)

Due to.....

Due to..... 49

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

Major findings:
Of operations.....

Of autopsy.....

Duration

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) (c) Means of injury.....

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

Address..... Date signed.....

S-13645