No. 2
1-4-41
-17-39
X26380

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. 27335

FILED SEP 12 1941

Registration District No. 1499

Primary Registration District No. 1002

Registrar's No. 2993

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 O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4-30-41-8-6-41 (Specify whether)

In this community 25 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 919 Garfield 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: O

3. (a) PRINT FULL NAME: TOY ELLINGTON

3. (b) If veteran, name war:

3. (c) Social Security No.: —

4. Sex: Female 2

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Roy Ellington

6. (c) Age of husband or wife if alive: 53 years

7. Birth date of deceased: January (Month) 29 (Day) 1893 (Year)

8. AGE:

Years	Months	Days	If less than one day
48	6	16	hr. min.

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

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Unknown Deceased
13. Birthplace: Unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Deceased Unknown
15. Birthplace: Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant: Record Clerk

(b) Address: General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Blue Ridge Lawn

18. (a) Signature of funeral director: H. B. Crowe

(b) Address: 1820 E. 18th Street

19. (a) 8/7/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6th year 1941 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from 4-30-41, 19__, to 8-6-41, 19__; that I last saw her alive on August 6th, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Heart Disease with right hemeplegia

Due to: Diabetes Mellitus

Cerebro-vascular accident

Due to: possible thrombosis

Other conditions (Include pregnancy within 3 months of death): N

Major findings:
Of operations: 61

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: [illegible] (M.D. or other)

Address: General Hosp #2 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 me

H B Moore, Registered Apprentice No.

working under my personal supervision.

Signed H B Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E 18th st

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

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