

FILED OCT 13 1941

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

30692

State File No. 3449

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:
3516 Nicholson Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 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") 8
(d) Street No. 3516 Nicholson
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14
year 1941 hour 11:40 minute 0 M.

21. I hereby certify that I attended the deceased from April
off and on, 1941, to Sept 13, 1941;
that I last saw her alive on Sept 13, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration 6 to 8
following Myocardial Regeneration months

Due to Dilatation of heart

Due to Toxic gases
introduced to her apartment
Other conditions Several Hospital
(Include pregnancy within 3 months of death)

Major findings:
Of operations 28
Of autopsy 658
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? E

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature E. F. Reilinger (M. D. or other) D
Address 520 Argyle Bldg. Date signed Sept. 15, 1941

3. (a) PRINT FULL NAME Grace May Helvestine

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

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

6. (b) Name of husband or wife James B. Helvestine 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased June 6, 1884
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 8 If less than one day hr. _____ min. _____

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

10. Usual occupation House Wife

11. Industry or business At Home

12. Name Robert D. Blue

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

14. Maiden name Sarah A. Druey

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

16. (a) Informant James B. Helvestine

(b) Address 3516 Nicholson Ave.

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

(c) Place: burial or cremation Oak Hill, Kansas

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 9/16/41 (b) M. Crow
(Date received local registrar) (Registrar's signature)

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

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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. Clair Sheppard

Licensed Embalmer No.

4177

P. O. Address

H. 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.