S. No. 2
—1-4-41
. 5-17-39
I X26390

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

(DUPLICATE) (OTHER CERTIFICATE LOST)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40968

FILED JAN 24 1942

Registration District No. 3-9-7 Primary Registration District No. 1002 Registrar's No. 4646

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 No. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 12-7-41-12-10-41 (Specify whether years, months or days)

In this community: Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 048

(c) City or town: Kansas City 3 (If outside city or town limits, write "RURAL") 8

(d) Street No.: 1417 Forest (If rural, give location)

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

If yes, name country: n

3. (a) PRINT FULL NAME: ELZORA HARDY

3. (b) If veteran, name war: No

3. (c) Social Security No.: Unk

4. Sex: Female 2

5. Color or race: Negro

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

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: May (Month) 12 (Day) 1907 (Year)

8. AGE: Years 34 Months 6 Days 28 If less than one day: hr. min.

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

10. Usual occupation: Unemployed

11. Industry or business:

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

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

16. (a) Informant: Record Clerk

(b) Address: General Hospital #2

17. (a) Remove (Burial, cremation, or removal) (b) Date thereof: 12-15-1941 (Month) (Day) (Year)

(c) Place: burial or cremation: Pawhuska Okla.

18. (a) Signature of funeral director: Irving Home

(b) Address: 1513 Troost

19. (a) Dec 14, 1941 (Date received by local registrar) (b) M. M. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 10 year: 1941 hour: 8 minute: 00 p. M.

21. I hereby certify that I attended the deceased from December 7, 1941 to December 10, 1941 that I last saw her alive on December 10, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute pulmonary Edema with uremia

Due to: Malignant type hypertension

Due to:

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

Major findings:
Of operations:
Of autopsy: Same as above

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: B. C. Thomas (M.D. or other)

Address: Gen. Hosp #2 600 E 22 Date signed: 12-16-41

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed. [illegible]

Licensed Embalmer No. 3388

P. O. Address K. C. MO.

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

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

V. S. No. 2B
10M—8-21-41
I X29288

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. 40968

Registration District No. 399 Primary Registration District No. 102 Register's No. 4646

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)
In this community: —

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(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: Elzora Hardy
3. (b) If veteran, name war: —
3. (c) Social Security No. —
4. Sex: F
5. Color or race: B
6. (a) Single, widowed, married, divorced: w
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: May 12, 1907 (Month) (Day) (Year)
8. AGE: Years 34 Months 6 Days 18 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 10 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	
Due to: Acute Urinary Suppression	
Due to:	
Other conditions: A Benign Nephrosclerosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: 131a

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: J. O. Dunne (M.D. or other)
Address: Gen. Hosp. #2-600 E 22 Date signed 2-2-42

SUPPLEMENTARY