

No. 2
1-4-41
17-39
X25390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5406

FILED MAR 9 1942 399
Registration District No.

Primary Registration District No. 1002

State File No.

Registrar's No. 452

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:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
(Specify whether years, months or days)
In this community 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3009 East 32nd 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 Feb. day 1st
year 1942 hour 12 minute 30 A.M. M.
21. I hereby certify that I attended the deceased from 11-1-41 19 to 2-1-42 19
that I last saw her alive on 2-1-42 19
and that death occurred on the date and hour stated above.

Immediate cause of death:
Intertrochanteric fracture of left femur sustained in accidental fall in hospital on 11-15-41
Paranoia
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death)
186a
17

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence 11-15-41
(c) Where did injury occur? In Hosp. Psychopathic Dent.
(City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Psychopathic Ward K.C.G.n. Hospital
While at work? _____ (Specify type of place) _____ Means of injury Slipped and fell
23. Signature Dr. M. M. Crowe (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

3. (a) PRINT FULL NAME Ella E. Irwin

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 Widowed

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

7. Birth date of deceased March 27, 1863
(Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Wife

11. Industry or business At Home

MOTHER FATHER { 12. Name William Cosley
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name No Record
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant Wm. C. Irwin

(b) Address 5407 Brooklyn

17. (a) Burial (b) Date thereof 2-2-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

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

(b) Address 918 Brooklyn

19. (a) 2-2-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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(Licensed Embalmer's Statement on Reverse Side)

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

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 Shippard*
Licensed Embalmer No. *7179*
P. O. Address *K. C. Mo.*

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.