

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 12 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **1596**

Registration District No. **399**

Primary Registration District No. **1002**

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 **6 days** (Specify whether
In this community **40 yrs** years, months or days)

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. **324 Wabash** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ella Harelson**
3. (b) If veteran, **no** name war _____
3. (c) Social Security No. **no**

4. Sex **Femal** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Wid**
6. (b) Name of husband or wife **Cary Harlson** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Aug 7 1868**
(Month) (Day) (Year)

8. AGE: Years **73** Months **8** Days **12** If less than one day
hr. _____ min.

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

10. Usual occupation **At home**

11. Industry or business _____

MOTHER FATHER { 12. Name **I Ingram**
13. Birthplace _____ **Ky.** (City, town, or county) (State or foreign country)
14. Maiden name **No Records**
15. Birthplace _____ **Ky.** (City, town, or county) (State or foreign country)

16. (a) Informant **Beulah Helm**
(b) Address **711 Paseo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **April 23 1942**
(Month) (Day) (Year)
(c) Place: burial or cremation **Forest Hill Cem.**

18. (a) Signature of funeral director **Mrs C.L. Forster**
(b) Address **918 Brooklyh**

19. (a) **4-23-42** (Date received local registrar) (b) **M. M. Crowe** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **19th**
year **1942** hour **5** minute **15** A.M. M.

21. I hereby certify that I attended the deceased from **4-13-42**, 19____, to **4-19-42**, 19____
that I last saw h. **er** alive on **4-19-42**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral hemorrhage; hypertension

Due to _____
Due to _____

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

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 _____
(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 _____

23. Signature **Mary R. Flom** (M. D. or other) _____
Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

