

Registration District No.

Primary Registration District No. 1002

48
830

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether
In this community 14 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 999
(c) City or town Ottawa 17
(If outside city or town limits, write "RURAL") 0
(d) Street No. 727 S. Oak Street
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country X 2

3. (a) PRINT

FULL NAME MRS. JENNIE HOUSE

3. (b) If veteran, No.

3. (c) Social Security

name war No.

No. No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

John C. House

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

7. Birth date of deceased

July
(Month)

29
(Day)

1872
(Year)

8. AGE:

Years

Months

Days

If less than one day

69 20

2 11

3 4

hr. min.

9. Birthplace

Missouri
(City, town, or county)

0
(State or foreign country)

10. Usual occupation

at home

11. Industry or business

X

12. Name

Linus F. Parrish,

13. Birthplace

Illinois, 1
(City, town, or county) (State or foreign country)

14. Maiden name

Wattie Reynolds,

15. Birthplace

Indiana, 1
(City, town, or county) (State or foreign country)

16. (a) Informant

Louis A. House,

(b) Address

103 E. 51st St. Ter., K. C., Mo.

17. (a)

Removal
(Burial, cremation, or removal)

(b) Date thereof

8-2-42
(Month) (Day) (Year)

(c) Place: burial or cremation

Ottawa, Kansas

18. (a) Signature of funeral director

Stins & McClure,

(b) Address

3235 Gilliam Plaza, K. C., Mo.

19. (a)

8-3-42
(Date received local registrar)

(b)

M. M. Clouse
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2nd
year 1942 hour 8:05 minute A. M.

21. I hereby certify that I attended the deceased from July 19
1942 to Aug 11, 1942
that I last saw her alive on August 11, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure

Due to Acute Disseminated Lupus Erythematosus

Due to Sunlight Sensitivity

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy Not granted

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? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature David B. Morgan (M. D. or other) _____
Address 1524 Prof B Bldg Date signed 8-2-42
Kansas City, Mo.

361

Supplementary for additional
cause of death diagnosis
mailed to Doctor on this
case.

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.....

Licensed Embalmer No. 1415

P. O. Address. 15th St. N.W.

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **2918**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Mrs. Jennie Emily House**

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

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 **8/3/42**

19. (a) (Date received local registrar) (b) **J. J. Orsoe** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County.....
(c) City or town **Ottawa**
(If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **2nd**
year **1942** 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.

Immediate cause of death **Heart failure**
Due to toxic myocarditis

Due to **acute disseminated lupus erythematosus**

Due to **Sunlight sensitivity** *g3a*

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) (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S 23437