

State File No. _____

FILED JAN 21 1943 149
 Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 79

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

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:
6143 Cherry Street
 (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)

3. (a) PRINT FULL NAME Mrs. Ellen Gill Amos
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Mr. John Amos
 6. (c) Age of husband or wife if alive 7 years (Day) (Year)

7. Birth date of deceased February 7 1851
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 11 0 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Thomas W. Scrivner

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

14. Maiden name Sarah Ellen Harrison

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

16. (a) Informant Mrs. Inez A. Phillip
 (b) Address 6143 Cherry

17. (a) Burial, cremation, or removal Burial (b) Date thereof 8-43
 (Month) (Day) (Year)
 (c) Place: burial or cremation 11111 Mt. Moriah Cemetery

18. (a) Signature of funeral director D. H. Newcomer, son
 (b) Address 1401 Brush Creek Blvd.

19. (a) 1-8-43 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 999
 (a) State Iowa (b) County Appanoose
 (c) City or town Cincinnati
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____ 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7th
 year 1943 hour 3 minute 40 A. M.

21. I hereby certify that I attended the deceased from December 18 to Jan 7
 that I last saw her alive on Jan 6 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular disease
vascular disease
 Due to senility

Due to 1210
 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 Emmanuel R. Paul (M. D. or other)
 Address 1601 Kenia, Keokuk, Iowa Date signed 1/14/43

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

1607
2-5-30
Newcomer

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 *H. C. Newcomer Jr*
Licensed Embalmer No. 4073
P. O. Address St. 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.