U. S. No. 2
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Form I X32873

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5379

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1072

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:
Touraine Apt. Hotel-1412 Central
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community 60 years

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson 3
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 1412 Central
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Emily Mittilda Nast
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 Frank Nast
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased September (Month) 15 (Day) 1859 (Year)
8. AGE: Years 83 Months 5 Days 13 If less than one day ..... hr. ..... min.
9. Birthplace Leavenworth (City, town, or county) Kansas (State or foreign country)
10. Usual occupation At Home
11. Industry or business .....
FATHER
12. Name William Melchert
13. Birthplace Not Known (City, town, or county) Not Known (State or foreign country) 9
MOTHER
14. Maiden name ?? Sparr
15. Birthplace Not Known (City, town, or county) Not Known (State or foreign country) 9
16. (a) Informant Ida Mae (Nast) Barger
(b) Address Touraine Apts. 1412 Central
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-43 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cemetery
18. (a) Signature of funeral director J. F. O'Donnell Co.
(b) Address 3256 Broadway
19. (a) 3-2-43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February Day 28 th, Year 1943 hour 10 minute 35 A.M.
21. I hereby certify that I attended the deceased from Feb 26, 1943 to Feb 28, 1943; that I last saw her alive on Feb 27, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	2 days
Due to Hypertension	1 yr
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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) None
(b) Date of occurrence None
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? None (Specify type of place)
While at work? None (e) Means of injury 0
23. Signature Glenn Cochran (M. D. or other physician designated by coroner)
Address 114 Bryant Bldg K.C. Mo. March 1, 1943

(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 Paul G. Rowe

Licensed Embalmer No. 2347

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.