

X32873

Registration District No. 1043/49

Primary Registration District No. 1062

Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: 1720 Indiana
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 15 yrs (years, months or days)

3. (a) PRINT FULL NAME Mary Ellen Elliott
3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Femal 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Nathaniel Elliott 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 27 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	6	1	_____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business Thomas O'Leary

MOTHER FATHER
12. Name Ireland
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Mary Sullivan
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Jones
(b) Address 1811 Stine Kansas City Kas.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30 1943
(Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cem.

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

19. (a) 3-29-43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

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. 1720 Indiana
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 28
year 1943 hour 11 minute 30A M.
21. I hereby certify that I attended the deceased from 19 to 19
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy Arteriosclerotic heart disease

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. M. Brown (M. D. or other) _____
Address _____ Date signed _____

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.....

P. O. Address.....

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.