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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 13 1943

Registration District No. 154

Primary Registration District No. 5075

Registrar's No. 48

1. PLACE OF DEATH: Jackson

(a) County Kansas City-Mo

(b) City or town Home
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home Washington Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Home (Specify whether years, months or days) 30 Years

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 7918 Chestnut (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME DELLA D. HOTTLE

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11 year 1943 hour 1 AM minute _____ M.

4. Sex fe

5. Color of race wh

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

6. (b) Name of husband or wife Husband

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased march 4 (Month) 1888 (Day) (Year)

21. I hereby certify that I attended the deceased from 7/11, 1943 to 7/11, 1943 that I last saw her alive on June 29, 1943 and that death occurred on the date and hour stated above.

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

55 4 7 _____ hr. _____ min.

Immediate cause of death: Cerebral thrombosis 3 yrs

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

Due to _____

Due to _____

Other conditions: 552 (Include pregnancy within 3 months of death)

10. Usual occupation: hu House wife

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name John Falls

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

14. Maiden name Unknown

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Howard C. Hottle

(b) Address 7918 Chestnut

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof 7 13 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cem

(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? _____

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address 1800 Linwood

While at work? _____ (Specify type of place)

Means of injury? _____

19. (a) 7/10/43 (Date received local registrar)

[Signature] (Registrar's signature)

23. Signature [Signature] (M. D. or D. O.)

Address 1103 Grand Ave Date signed 7/12/43

Dr. Annie G. Hedger Licensed Embalmer's Statement on Reverse Side

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

o. 2
2-43
7-43
X388

Br

Dr Virden

St Joseph Hospital

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.....

Chaswell

Licensed Embalmer No.....

2644

P. O. Address.....

1800 Linwood

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.

HUG 23 1943

Registration District No. 104

Primary Registration District No. 5570

Registrar's No. 122

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Russell City 1918 District
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rural - Washington Township
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Della D. Hattie

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: mar 4 1888
(Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days _____
(Unless than one day) min. _____

9. Birthplace Missouri
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: _____
 Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

AUG 13 1947

State File No.

Registrar's No.

Registration District No. 109

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(c) Name of hospital or institution:
(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 Richard Halth

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

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

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

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

8. AGE: Years Months Days (Unless than one day) min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name { 13. Birthplace (City, town, or county) (State or foreign country) { 14. Maiden name (City, town, or county) (State or foreign country) { 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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1947 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19... 19... that I last saw him alive on 19... and that death occurred on the date and hour stated above. Immediate cause of death

Due to Probably from uterine carcinoma reported from history 16 yrs ago - no other source demonstrated. Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations H&H Of autopsy

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) (c) Means of injury

23. Signature (M. D. or other) Date signed 8/21/47

SUPPLEMENTARY

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