

S. No. 2
 FORM-2-43
 Rev. 5-1-41
 U.S. G.P.O.

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **27368**
 Registrar's No. **3533**

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

FILED AUG 27 1943 149
 Registration District No. 149

Primary Registration District No. 1002

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:
4940 East 24th. Street
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Weeks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Madge K. Kella
 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 Married
 6. (b) Name of husband or wife Roy C. Kella
 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased December 18th. 1904
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------------------|----------------------|
| | 38 | 7 | 27 ²⁵ | hr. min. |

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

10. Usual occupation Housewife

MOTHER FATHER
 11. Industry or business
 12. Name John Franklin Crouse
 13. Birthplace Pa
 14. Maiden name Frances Blaine
 15. Birthplace Ill

16. (a) Informant Roy C. Kella

(b) Address North K.C. 7th Raut #2

17. (a) Removal (b) Date thereof Aug 17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cherryvale Mausoleum

18. (a) Signature of funeral director Wm. K. Foster

(b) Address 918 Brooklyn K.C. Mo

19. (a) 8-16-43 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Clay
 (c) City or town R. F. D. # 5 North K. C. Mo.
(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 August day 13th.
 year 1943 hour 11 minute P. M.
 21. I hereby certify that I attended the deceased from 11/15/43
 to 8/12/43
 that I last saw h. aw alive on 8/12/43
 and that death occurred on the date and hour stated above.

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

Duration 2-3 mo
15-20 yrs
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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 Commercial Bldg Date signed 8/14/43
 Address _____

Dr. Dunham North Kansas City Mo.

Commercial Body N - R E No
Tel. No: 3.838 -

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 *Denzil E. Browning*.....

Licensed Embalmer No. *27564*.....

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.