

S. No. 2
M-2-43
7. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33715

State File No. _____

ED. NOV 1 1943 149
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4366

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:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether _____)

In this community unknown
years, months or days

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. 616 N. Park
(If rural, give location)

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

3. (a) PRINT FULL NAME Ella Brewer

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

7. Birth date of deceased Dec 25 1876
(Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name A. D. Dilley

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

14. Maiden name unknown

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

16. (a) Informant Head Clerk

(b) Address R. E. Sun Dept

17. (a) Burial (b) Date thereof Oct 14 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funerary

18. (a) Signature of funeral director Wm A. Johnson

(b) Address City, Missouri

19. (a) 10-14-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12th
year 1943 hour 11 minute 10 P.

21. I hereby certify that I attended the deceased from Oct. 8th 1943 to Oct. 12th 1943
that I last saw her alive on Oct. 12th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Mesenteric thrombosis with gangrene of intestine
Duration _____

Due to _____

Due to 1231

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

Major findings: Of operations _____

Of autopsy See above

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 Drury R. Thorn (M. D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 10-13-43

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

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.