S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 3 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37392

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4811

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: 4726 PARK AVENUE /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ------- (Specify whether
In this community 62 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4726 PARK AVENUE 8
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country ------- 0

3. (a) PRINT FULL NAME MRS. SARAH ELLEN MANSFIELD

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~~ MR. Joaquin F.

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

7. Birth date of deceased OCTOBER (Month) 2 (Day) 1858 (Year)

8. AGE: Years 85 Months 1 Days 11 If less than one day ..... hr. ..... min.

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

10. Usual occupation AT HOME

11. Industry or business

FATHER
12. Name WILLIAM DODSON
13. Birthplace (City, town, or county) INDIANA / (State or foreign country)

MOTHER
14. Maiden name EVE HOUZE
15. Birthplace UNKNOWN (City, town, or county) INDIANA / (State or foreign country)

16. (a) Informant MR. WALLACE F. MANSFIELD

(b) Address 4726 PARK AVENUE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV-16-1943 (Month) (Day) (Year)

(c) Place: burial or cremation SHAWNEE CEMETERY SHAWNEE KANSAS

18. (a) Signature of funeral director D. N. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 11-15-43 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 13TH year 1943 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from October 20, 1936, to Nov 13, 1943; that I last saw her alive on Nov 13, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Chronic Cardiac Vascular Disease

Due to 92d

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury?

23. Signature [signature] (M. D. or other) MD

Address [illegible] Date signed 11/16/43

(Licensed Embalmer's Statement on Reverse Side)

Professional Reg.

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.