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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38376

State File No. 382

FILED NOV 22 1943

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 258

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Independence Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 week (Specify whether years, months or days)  
In this community 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Independence  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1513 W. College st 7  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country D

3. (a) PRINT FULL NAME Grace Dennis

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

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married divorced married  
6. (b) Name of husband or wife Ira Dennis 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Month 31 - 1907 (Month) (Day) (Year)

8. AGE: Years 36 Months 6 Days 6 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER { 12. Name John Ingram  
13. Birthplace Scotland (City, town, or county) (State or foreign country)  
14. Maiden name Jane Clark  
15. Birthplace Scotland (City, town, or county) (State or foreign country)

16. (a) Informant Helen Burgess

(b) Address 115 W. Ind. Ave. Ind. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/43 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Cem.

18. (a) Signature of funeral director Robert R. Specker

(b) Address Independence, Mo.

19. (c) 10-9-43 (Date received local registrar) (d) James Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day Seventh year 1943 hour 2 minute 30 p. M.

21. I hereby certify that I attended the deceased from September 15 1943 to Oct 7 1943 that I last saw her alive on Oct 7 1943 and that death occurred on the date and hour stated above.

Immediate cause of death acute pneumonia Duration 2 yrs

Due to arterial hypertension

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Controlled Reducible

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) (Specify nature of injury)

23. Signature Robert R. Specker (M. D. or other) Address Independence, Mo. Date signed 10/19/43

PHYSICIAN Underline the cause to which death should be charged statistically.

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

1165

(Licensed Embalmer's Statement on Reverse Side)

**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 my

..... Registered Apprentice No. ....

working under my personal supervision.

Signed

Poland R. Penke

Licensed Embalmer No. 3604

P. O. Address Indy, Ind.

**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.**

Registration District No. 146

Primary Registration District No. 3026

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Grace Dennis

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 march 31  
(Month) (Day) (Year)

8. AGE: Years 36 Months 6 Days 13 If less than one day..... min.

9. Birthplace Scotland  
(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.....  
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 CERTIFICATE

20. DATE OF DEATH: Month Dec Year 1943 hour 7 minute..... M.

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

Arterial hypertension  
due to chronic & acute  
nephritis with contracted  
kidney.

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

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..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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PHYSICIAN

Underline the cause to which death should be charged statistically.

38376