

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10018

State File No.

Registrar's No. **5022**

FILED DEC 22 1943/9

Registration District No. 779

Primary Registration District No. 1002

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

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 50 years
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. 3217 Cleveland
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elizabeth Hall

3. (b) If veteran, name war No.

3. (c) Social Security No. No. 218

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27
year 1943 hour 10 minute 30 A. M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Mr. Samuel B. Hall

6. (c) Age of husband or wife if alive 29 years (Month) Dec (Day) 29 (Year) 1857

21. I hereby certify that I attended the deceased from November 23, 1943 to November 27, 1943
that I last saw her alive on November 27, 1943
and that death occurred on the date and hour stated above.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
| | <u>91</u> | <u>10</u> | <u>29</u> | hr. min. |

Immediate cause of death Cardiac failure.
Hypertensive Heart Disease

9. Birthplace New York, 1
(City, town, or county) (State or foreign country)

Due to _____

Due to 93A

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Prop.

11. Industry or business Blooming House

Major findings:
Of operations _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Harry F. Kroese

(b) Address Pittsburg Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29 43
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

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? _____

18. (a) Signature of funeral director W. W. Newcomer

(b) Address 11-29-43

19. (a) 11-29-43 (Date received local registrar) (b) D. E. Burton (Registrar's signature)

23. Signature Dwight R. Thorne (M. D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 11-29-43

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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 *Ernie M Calhoun*.....

Licensed Embalmer No. *3506*.....

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.