

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(c) Name of hospital or institution: West Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 2 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lallie B. Mc Gooch.

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

4. Sex FE 5. Color or race Wh

6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address 1550 N. Liberty

17. (a) Removal (b) Date thereof Dec 30
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Franklin Mo

18. (a) Signature of funeral director Duncan Funeral Home

(b) Address New Franklin Mo

19. (a) 12-30-1943 (Date received local registrar) (b) Samuel Rose (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 1550 N. Liberty
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec - day 30 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept 1943 to Dec 30 1943
that I last saw her alive on Dec 25 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 30 days

Due to arteriosclerosis chronic

Due to _____

Other conditions arteritis deformans chronic
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓
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 J. H. Thacker (M. D. or other) _____

Address Independence Mo Date signed Dec 30

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..... *Chas Wilks*

Licensed Embalmer No. *2644*

P. O. Address. *Kansas City 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.