

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 13 1944

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **310851**
Registrar's No. **229**

Registration District No. **176** Primary Registration District No. **3026**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Independence, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
505 West South Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1** (Specify whether
In this community **One Month**
years, months or days)

3. (a) PRINT FULL NAME **FANNIE E. LARSON**
(b) If veteran, name war **None**
(c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced, **Widowed**
(b) Name of husband or wife
(c) Age of husband or wife if alive **1891** years
7. Birth date of deceased **Oct. -29-** (Month) (Day) (Year)

8. AGE: Years **62** Months **11** Days **5**
If less than one day hr. min.

9. Birthplace **Oil City Penn. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation
11. Industry or business

MOTHER FATHER

12. Name **Charles F. Pryor**
13. Birthplace **Venango Co. town Penn 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Laura Solinger**
15. Birthplace **Venango Co. Penn 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Harry Pryor**
(b) Address **505 West South Ave. Indep. Mo.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-7-44** (Month) (Day) (Year)
(c) Place: burial or cremation **Mound Grove**

18. (a) Signature of funeral director **George C. Carson**
(b) Address **Independence, Missouri**
19. (a) **9-4-1944** (Date received local registrar) **James Row** (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. **505 West South Avenue**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **4**
year **1944** hour **8:30** minute **A.** M.
21. I hereby certify that I attended the deceased from **Aug 28-1944**
Sept. 4 1944, to **Sept. 4** 1944,
that I last saw h. or alive on **Sept 4** 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage
Due to
Due to
Other conditions (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) Means of injury
23. Signature **Chris H. Lee** (M. D. or other)
Address **7608 Independence Ave** Date signed **9/4/44**

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

1163

(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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Thos. J. Hansen

..... Licensed Embalmer No. *4199*

-P: O: Address *Indpls. 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 years, months or days)

3. (a) PRINT FULL NAME Farmel E. Larson
 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 W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct 29 (Month) (Day) (Year)

8. AGE: Years 62 Months 1 Days _____ If less than one day _____ min.

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

10. Usual occupation Retired

11. Industry or business Housewife

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) James W. Rose
(Date received local registrar) (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 CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
 Due to _____
 Other conditions _____
(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 _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

31085