

FILED OCT 24 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

33173  
 State File No. \_\_\_\_\_  
 Registrar's No. 4047

Registration District No. 199 Primary Registration District No. 1003

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: 3234 Prospect Avenue  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 25 years (Specify whether 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. 3234 Prospect Avenue  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME MATTIE ELIZABETH HAIL  
 (b) If veteran, name war No  
 (c) Social Security No NONE

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct day 6<sup>TH</sup>  
 year 1944 hour 3 minute 130 M.

4. Sex FEMALE 5. Color or race White  
 6. (a) Single, widowed, married, divorced, or widower Widowed  
 (b) Name of husband or wife George J. Hail  
 (c) Age of husband or wife if alive 3-1866 years  
 7. Birth date of deceased May 3-1866 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9/11/44, 19, to 10/6/44, 19, that I last saw her alive on 10/6/44, 19, and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 5 Days 3 If less than one day hr. min.

Immediate cause of death: Coronary occlusion

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

Due to: Coronary occlusion  
 Due to: Ch. Intestinal neoplasm, Hypertension

10. Usual occupation at home

Other conditions: (Include pregnancy within 3 months of death)  
 Major findings: 1310

MOTHER FATHER  
 11. Industry or business  
 12. Name Geo. H. Kenney  
 13. Birthplace UNKNOWN Ohio (City, town, or county) (State or foreign country)  
 14. Maiden name Jennie Barrett  
 15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

Of operations:   
 Of autopsy: none  
 PHYSICIAN: Underline the cause to which death should be charged statistically.

16. (a) Informant MR. CHARLES A. HAIL  
 (b) Address 3234 PROSPECT AVENUE  
 17. (a) BURIAL (b) Date thereof OCT-9-1944 (Month) (Day) (Year)  
 (c) Place: burial or cremation MEMORIAL PARK CEM.

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 D. N. Newsome's Sons  
 (b) Address 1401 BRUSH CREEK BLVD.  
 19. (a) 10-9-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

While at work?  (Specify type of place)  
 (e) Means of injury: \_\_\_\_\_  
 23. Signature D. E. Brown (M. D. or other)  
 Address 4800 S. 2nd St. Date signed 10/7/44

W. D. C. ...  
7500 East 24th Street  
1:40, 4:40

BPH

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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.....

working under my personal supervision.

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

Signed.....

*Elsear Torrey*

Licensed Embalmer No. 1767

P.O. Address 140 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:**