DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37938

FILED NOV 24 1944

Registration District No. 154 — Primary Registration District No. 5575 — Registrar's No. 67

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Kansas (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ~~None~~ 8403 Wornall Rd (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community 3 mo. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Franklin

(c) City or town Richmond Kansas (If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 7

3. (a) PRINT FULL NAME Eliza C. Heinis

3. (b) If veteran, name war .....

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 1

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased July (Month) 25 (Day) 1857 (Year)

8. AGE: Years 87 Months 2 Days 16 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Robt. L. Laughlin
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rebecca
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Robt. L. Heinis

(b) Address 8403 Wornall Rd

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-44 (Month) (Day) (Year)

(c) Place: burial or cremation Richmond Kans.

18. (a) Signature of funeral director Harlyn Roe

(b) Address 7406 Wornall

19. (a) 11/15/44 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21st year 1944 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from October 9th, 1944, to Oct. 21, 1944; that I last saw her alive on Oct 20th, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Emaciation

Due to Cancer of Liver

Due to Old age

Other conditions (Include pregnancy within 3 months of death) H6

Major findings: Of operations None

Of autopsy ✓

Duration

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? (Specify type of place)

While at work? (e) Means of injury 2

23. Signature Geo. F. Clark (M.D. or other)

Address 408½ W. 75 Date signed 10-22-44

(Licensed Embalmer's Statement on Reverse Side)

1152

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.....

Licensed Embalmer No. 2810

P. O. Address. 15 E. 2nd

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 154 Primary Registration District No. 55751 Registrar's No. 67

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Washington
(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)

In this community

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

3. (a) PRINT FULL NAME Elza C Heinis

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 July (Month) 25 (Day) 1857 (Year)

8. AGE: Years 87 Months 2 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2 year 1944 hour 6 minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — *Duration*

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

37938