

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 19 1945**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
Jackson County Home for Aged  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 yrs 9 mo  
(Specify whether years, months or days)

In this community 25 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. R.H. Independence  
(If rural, give location)

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

3. (a) PRINT FULL NAME Elizabeth Hixes Liff

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 11  
year 1944 hour 5:00 minute AM

21. I hereby certify that I attended the deceased from Dec 9, 1944 to Dec 11, 1944  
that I last saw her alive on Dec 11, 1944  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 4, 1862  
(Month) (Day) (Year)

Immediate cause of death:  
Right lobar pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>3</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Unknown

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 Ronald Jackson County Home  
(b) Address R.H. Independence

17. (a) Burial (b) Date thereof 12-14-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leis Summit Mo.

18. (a) Signature of funeral director N.B. Langford  
(b) Address Leis Summit Mo.

19. (a) Dec. 14, 1944 (b) E.M. Schick  
(Date received local registrar) (Registrar's signature)

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.W. Greene (M. D. or other) \_\_\_\_\_  
Address Independence Date signed 12/12/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1106

(Licensed Embalmer's Statement on Reverse Side)

12/12/44

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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 N. B. Langford  
Licensed Embalmer No. 3833  
P. O. Address Leo Summit 70

**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.**