7. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

Registration District No. 199

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5073

Primary Registration District No. 1002

Registrar's No. 809

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: K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 mo. 8 days (Specify whether years, months or days)
In this community: unknown

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.: 714 Harrison
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: O

3. (a) PRINT FULL NAME: Ethel Bius
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Female
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Elige Bius
6. (c) Age of husband or wife if alive: 65 years
7. Birth date of deceased: Aug (Month) 4 (Day) 1868 (Year)
8. AGE: Years 56 Months 6 Days 13 If less than one day hr. min.
9. Birthplace: Texas (City, town, or county) (State or foreign country)
10. Usual occupation: Housekeeper
11. Industry or business:
MOTHER FATHER
12. Name: J. H. Perkins
13. Birthplace: Texas (City, town, or county) (State or foreign country)
14. Maiden name: Anna Augustine
15. Birthplace: Germany (City, town, or county) (State or foreign country)
16. (a) Informant: Lillian Harper
(b) Address: 912 E 9
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenlawn
18. (a) Signature of funeral director: E. B. Lagetten
(b) Address: 15 E 9th Mo
19. (a) 2-19-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17 year 1945 hour 10 minute 10 A. M.
21. I hereby certify that I attended the deceased from January 9 1945 to February 17 1945 that I last saw her alive on February 17 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac decompensation	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: None

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: O

23. Signature: Clarke Sealy M.D. (M. D. or other)
Address: Med. Dir. Gen 1 Hosp. Date signed: 2-19-45

(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.....

Licensed Embalmer No. 17273

P. O. Address.....

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.