

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED MAY 3 1945
1945

Registration District No. 1002 Primary Registration District No. 1002

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: K. C. Osteopathic Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days
(Specify whether)

In this community 2 years
years, months or days

3. (a) PRINT FULL NAME Mrs. Zenna Noll Dilley

3. (b) If veteran, name war No

3. (c) Social Security No. 190201-0811

4. Sex Fe. / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife R. H. Dilley / 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased August 2, 1908
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| <u>36</u> | <u>8</u> | <u>23</u> | hr. _____ min. _____ |

9. Birthplace Santa Rosa, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Inspector

11. Industry or business Crystal Products Co.,

MOTHER FATHER

12. Name J. J. Noll

13. Birthplace Santa Rosa, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mattie Bearss

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mattie Noll

(b) Address 8827 Wilson Road

17. (a) Removal (b) Date thereof 4/25/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pattonsburg, Mo.

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address Kansas City, Mo.

19. (a) 4-25-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 8827 Wilson Road
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1945 hour 2:25 minute a.m.

21. I hereby certify that I attended the deceased from September
1944 to 4-25-1945

that I last saw her alive on 4-24-1945
and that death occurred on the date and hour stated above.

Immediate cause of death acute uremia - anemia 1 mo.

Due to malignant uterus with extensive metastases 1 year

Other conditions 48 hr
(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations none

Of autopsy Extensive malignant lesions - whole pelvis, liver, etc.

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 Margaret Jones (M.D. or other) P.O.

Address 3 E. 39th St. Date signed 4-25-45

K.C. 2 mo.

JAN 7 1946

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.....

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.