

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12211

Registered Death No. 31945
DECEASED MAY 3 1945

Primary Registration District No. 1002

Registrar's No. 1290

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. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether)

In this community 17 YEARS
(years, months or days)

3. (a) PRINT FULL NAME Mary A. Herriott

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MR. AARON L. HERRIOTT

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

7. Birth date of deceased: OCTOBER - 20 - 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 329
If less than one day hr. min.

9. Birthplace: GENOA OHIO 1
(City, town, or county) (State or foreign country)

10. Usual occupation: AT HOME

11. Industry or business: -----

MOTHER FATHER { 12. Name: JAMES HOPKINS

13. Birthplace: UNKNOWN ENGLAND
(City, town, or county) (State or foreign country)

14. Maiden name: MARY BUTLER

15. Birthplace: UNKNOWN PENNSYLVANIA
(City, town, or county) (State or foreign country)

16. (a) Informant: MISS HAZEL HERRIOTT

(b) Address: 4017 MAIN STREET

17. (a) REMOVAL (b) Date thereof: APR 22 1945
(Burial, cremation, or removal) (City, town, or county) (State) (Day) (Year)

(c) Place: burial or cremation: TOLEDO OHIO

18. (a) Signature of funeral director: W. A. Hewson's Sons

(b) Address: 1401 BRUSH CREEK BLDG.

19. (a) 4-21-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State: Missouri (b) County: Jackson

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

(d) Street No.: 4017 Main
(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 1945
year 1945 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from April 10 1945 to April 19 1945
that I last saw her alive on April 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion Duration

Fracture of right hip

Due to: -----

Due to: -----

Other conditions: 186a-5
(Include pregnancy within 3 months of death)

Major findings: None PHYSICIAN

Of operations: -----

Of autopsy: None

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): Accident: 23

(b) Date of occurrence: 4-10-45

(c) Where did injury occur? K.C. Jackson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work: no (Specify type of place)

(e) Means of injury: fall

23. Signature: Clark W. Seely, M.D. (M.D. or other)

Address: Med. Dir. Gen'l Hosp. Date signed: 4-20-45

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

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 *H. C. Newcomer Jr.*
Licensed Embalmer No. *4043*
P. O. Address *H. C. Newcomer*

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.