No. 2
9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 24 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12863

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 424

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 6-15-43
In this community Same (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town K. C Mo (If outside city or town limits, write "RURAL")
(d) Street No. 3811 E 68th. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME NELL HANDLEY

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 (divorced circled)
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 8 (Month) 15 (Day) 1881 (Year)

8. AGE: Years 62 Months 7 Days 21 If less than one day ... hr. ... min.

9. Birthplace Smithville Mo (City, town, or county) (State or foreign country)
10. Usual occupation Dress factory
11. Industry or business Dress factory
FATHER 12. Name J. H. Jenkins
13. Birthplace Mo (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Julia Powell
15. Birthplace Smithville Mo (City, town, or county) (State or foreign country)
16. (a) Informant Hosp. records
(b) Address
17. (a) Removal Kansas City (Burial, cremation, or removal) (b) Date thereof April 7-45 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo
18. (a) Signature of funeral director Walter Meierhoffer
(b) Address St. Joseph Mo
19. (a) 4-6-45 (Date received local registrar) (b) [signature] Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 6 year 1945 hour 9 minute 5 A.M.
21. I hereby certify that I attended the deceased from June 15, 1943, to 4-6, 1945
that I last saw her alive on Apr. 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic broncho pneumonia
Due to Intertrochanteric fracture
Due to fall on floor

Duration

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 E H Magee (M. D. or other) MD
Address State Hosp #2 Date signed 4/6/45

1511

(Licensed Embalmer's Statement on Reverse Side)

MAY 25 1945

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. C. Newcomer

Licensed Embalmer No. 470

P. O. Address Kansas City Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
1—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. May

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 4204

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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
In this community years, months or days)

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 Nell Handley

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 Div
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 15 (Day) 1881 (Year)
8. AGE: Years 63 Months 7 Days 25 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (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 April day 26
year 1945 hour 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.

	Duration
Immediate cause of death On Mar 10-1945 fell out of bed ~~and~~	
Due to received an intertrochanteric fracture, No displacement.	
Due to Occured in Hospital	
Other conditions (Include pregnancy within 3 months of death) lying on her back	
Major findings: Of operations caused the hypostatic pneumonia	
Of autopsy 1860-8 1860-9	

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 E H Magee (M. D. or other)
Address Date signed Apr 30 1945

SUPPLEMENTARY