

V. S. No. 2  
 FORM-5-43  
 Rev. 5-17-39  
 I X36571

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **19711**  
 Registrar's No. **2617**

**FILED JUL 3 1945**  
 Registration District No. **49**

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:  
3613 1/2 Independence Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days)

In this community 3 weeks  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Eleanor Tannehill

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Femal / 5. Color or race White

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 April 14 1932  
(Month) (Day) (Year)

**8. AGE:**

|           |          |          |                      |
|-----------|----------|----------|----------------------|
| Years     | Months   | Days     | If less than one day |
| <u>13</u> | <u>2</u> | <u>4</u> | hr. min.             |

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

10. Usual occupation School girl

11. Industry or business

12. Name Preston O. Tannehill

13. Birthplace Ky.  
(City, town, or county) (State or foreign country)

14. Maiden name Effie Harmon

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

16. (a) Informant Mrs Lee Bryan

(b) Address 3613 1/2 Indp. Ave.

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof June 19 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Bolckow Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 6-19-45 (Date received local registrar)

(b) Geraldine Helms (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

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

(d) Street No. --  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 18  
 year 1945 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from Crown, 1945, to 1945, 1945; that I last saw her alive on June 17 and that death occurred on the date and hour stated above.

Immediate cause of death Carbon monoxide poisoning

Due to Carbon monoxide poisoning

Due to Carbon monoxide poisoning

Other conditions 1780-14  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: History of 9 months

Of operations

Of autopsy No permit History of 9 months

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 6-18-45

(c) Where did injury occur? 3613 1/2 Independence Ave. Jackson Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In home  
(Specify type of place)

While at work? no (e) Means of injury East Furnace

23. Signature Geraldine Helms (M. D. or other)  
 Address 1424 Jefferson Date signed 6-15-45

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

*C. H. Wise*

Licensed Embalmer No.

*2570*

P. O. Address

*10 @ m*

**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.**