

**FILED** AUG 13 1945

State File No. \_\_\_\_\_  
Registrar's No. **3216**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1602**

**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: 1323 Brooklyn  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 52 yrs (Specify whether years, months or days)

In this community \_\_\_\_\_

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Jackson

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

(d) Street No. 1323 Brooklyn  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** ELIZABETH LA NEER

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race negro

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

6. (b) Name of husband or wife Earl La Neer

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased unknown  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>About 52</u>			hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Charley Wesley

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

14. Maiden name Allen

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

16. (a) Informant Mrs Alice Brown

(b) Address 1323 Brooklyn

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

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director C. H. Council

(b) Address 1708 Tracy

19. (a) 7-31-45 (Data received local registrar) (b) E. Waldine Holmea (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 29  
year 1945 hour 15 minute 30 A.M.

21. I hereby certify that I attended the deceased from 7-6-45 to \_\_\_\_\_ 19\_\_\_\_  
that I last saw her alive on 4-28 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death hypertensive heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 93 D  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

Means of injury \_\_\_\_\_

23. Signature J. M. Walden (M. D. or other) \_\_\_\_\_  
Address 6735 T road Date signed 7-30-45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 \_\_\_\_\_

Licensed Embalmer No. 1271

P. O. Address: K. C. Ohio

**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.**