V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32646

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4397

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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: 631 W 59th TERRACE 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution - - - - - (Specify whether
In this community 46 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 4

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 631 W 59th ST TERRACE 8
(If rural, give location)

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

If yes, name country - - - - -

3. (a) PRINT FULL NAME MRS. KATIE SUMMERS ELLIOTT

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 EDWARD WILSON ELLIOTT

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

7. Birth date of deceased APRIL (Month) 15 (Day) 1873 (Year)

8. AGE:

Years	Months	Days	If less than one day
72	6	9	hr. min.

9. Birthplace PLATTE COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation - - - -

11. Industry or business HOUSE WIFE

FATHER
12. Name CYRUS WITT
13. Birthplace PARKVILLE (City, town, or county) MISSOURI (State or foreign country)

MOTHER
14. Maiden name NANCY ELIZABETH WILLIAMS
15. Birthplace PARKVILLE (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant Mrs. P. P. Ham

(b) Address 3723 Wyoming

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-29-45 (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEMETERY

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 10-26-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 24th year 1945 hour 7 minute P M.

21. I hereby certify that I attended the deceased from 10-18-45, 19__, to 10-24-45, 19__; that I last saw her alive on 10-22-45, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bulbar paralysis	20 yrs
Due to: Cause unknown	
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	
Major findings: Of operations 82.1	
Of autopsy	

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? Means of injury

23. Signature [illegible] Wheeler (M. D. ~~or other~~)

Address 1500 Prop Bldg Date signed 10-25-45

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(Licensed Embalmer's Statement on Reverse Side)

Professional Bldg

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 K. C. Mo.

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.