

No. 2  
OM-5-43  
ev. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32785  
Registrar's No. 4283

FILED OCT 29 1945

Registration District No. 149

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: General Hospital #2 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hr. 50 min.  
(Specify whether years, months or days)

In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49

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

(d) Street No. 2510 Wabash 8  
(If rural, give location)

(e) Citizen of foreign country? No 0  
(Yes or No)

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

3. (a) PRINT FULL NAME Isabelle Mc Kittrick

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10th day 10  
year 1945 hour 11 minute 065 A. M.

21. I hereby certify that I attended the deceased from October 10,  
1945 to October 10, 1945

that I last saw her alive on October 10, 1945  
and that death occurred on the date and hour stated above.

4. Sex Female 3

5. Color or race Negro

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

6. (b) Name of husband or wife Dee McKittrick

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased 12 12 1882  
(Month) (Day) (Year)

Immediate cause of death Chronic Nephritis

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

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

Other conditions 131/15  
(Include pregnancy within 3 months of death)

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

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years 62 Months 9 Days 28  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Robert Edwards

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

14. Maiden name Amelia Greenfield

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

16. (a) Informant Ethel Warren

(b) Address 2501 Tracy

17. (a) burial (b) Date thereof 10/13/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn Cemetery

18. (a) Signature of funeral director Hathorne Bros.

(b) Address 1729 Lydia

19. (a) 10-18-45 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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: Car  
(M. D. or other)

23. Signature G. C. S. 10/12/45  
Address General Hospital #2 Date signed 10/12/45

**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

*Jerome Manlove*

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

**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.**