

S. No. 2
DOM-5-43
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36354**
Registrar's No. **4862**

Registration District No. 149 Primary Registration District No. 1002

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:
3210 E 111
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 years (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3210 E 111
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME NELLIE DAY PRAMEY
(b) If veteran, name war none
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 25
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Nov. 9
1945, to Nov. 25, 1945
that I last saw her alive on Nov. 24, 1945
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Wht
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Nov 10 1877
(Month) (Day) (Year)

Immediate cause of death Pneumonia
Due to arteriosclerosis
Due to _____
Other conditions (Include pregnancy within 3 months of death) 107

8. AGE: Years 68 Months 0 Days 15 If less than one day
hr. _____ min. _____

9. Birthplace Gulbia Ill
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____

Major findings: Of operations none
Of autopsy none
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER { 12. Name John Green
13. Birthplace New York, N.Y.
(City, town, or county) (State or foreign country)
14. Maiden name Eleanor Green
15. Birthplace Ill
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Star D. Ramsey
(b) Address 3210 E 111
17. (a) Burial (b) Date thereof Nov 26 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Clatski, Kans.

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) (e) Means of injury _____
23. Signature M. D. [unclear] (M. D. or other)
Address 1303 W. [unclear] Date signed 11/26/45

18. (a) Signature of funeral director [unclear]
(b) Address 2657 [unclear]
19. (a) 11-26-45 (b) [unclear]
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

18
3
8
11-26-45

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:.....

F. S. Walton

Licensed Embalmer No.

2744

P. O. Address.....

3030 Harrison

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.