

V. S. No. 2
 FORM-5-43
 Rev. 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

40213
 State File No.

FILED DEC 21 1945
 199

Registration District No. 1002
 Primary Registration District No. 1002

Registrar's No. 4973

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 No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
(Specify whether)
 In this community 40 YEARS
years, months or days

3. (a) PRINT FULL NAME Maude Nell
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex 7 / 5. Color or race W
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife BENJIMAN F. NALL
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased 1 16 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>10</u>	<u>15</u>	hr. _____ min.

9. Birthplace LAWSON, MO
(City, town, or county) (State or foreign country)
 10. Usual occupation HOUSEKEEPER
 11. Industry or business HOUSEWORK
 12. Name JOSEPH H. COLE
 13. Birthplace CINCINNATI, OHIO
(City, town, or county) (State or foreign country)
 14. Maiden name HONES FARRIS
 15. Birthplace ORRICK, MO
(City, town, or county) (State or foreign country)

16. (a) Informant Mildred Duffield
 (b) Address Wellington, Mo.
 17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 4 45
(Month) (Day) (Year)
 (c) Place: burial or cremation 8 MT. HOPE, MO.
 18. (a) Signature of funeral director Gary Bran
 (b) Address 1416 Minnesota
 19. (a) 12-3-45 (Date received local registrar) (b) A. Geraldine Holmes (Registrar's signature)

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. 1323 Forest
(If rural, give location)
 (e) Citizen of foreign country? No
(Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 1
 year 1945 hour 11 minute 35 A. M.

21. I hereby certify that I attended the deceased from Nov. 23, 1945, to Dec. 1, 1945
 that I last saw her alive on Dec. 1, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis and acute circulatory failure
 Due to Intracapsular fracture left femur

Due to _____
 Other conditions 186 a's
(Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy See above

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence 11-23-45
 (c) Where did injury occur? K. C. Jackson, Mo.
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
 While at work? No (Specify type of place) (e) Means of injury Fall
 Signature Clark W. Sisk
 Address Med. Dir. Gen'l Hosp. Date signed 12-3-45

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 Lee Clark

Licensed Embalmer No. 4216

P. O. Address: 1416 Minnesota

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.