

FILED DEC 29 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 5572

Registrar's No. 152

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Prairie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Jackson County E. Hospital
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 1 month
In this community 15 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 127 1/2 So. Park
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

FRANK DELL

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race wh. 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Feb 16 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Belkirk Canada
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Retired

12. Name Levi Dell

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

14. Maiden name Unknown

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

16. (a) Informant Charles L. Dell (son)

(b) Address 127 1/2 So Park Indep Mo

17. (a) Burial (b) Date thereof 11/24/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ground home

18. (a) Signature of funeral director Coland R. Sparks

(b) Address Independence Mo

19. (a) 11/28/45 (b) Carl E. Lane
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21st
year 1945 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from October 24-1945 19____ to Nov. 21-1945 19____
that I last saw him live on Nov. 21-1945 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

While at work? No (Specify type of place) (c) Means of injury _____

23. Signature W. Tuttle (M. D. or other) MD

Address Blue Springs, Mo Date signed 12/45

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.....

Roland R. Speaks

Licensed Embalmer No. *3604*

P. O. Address *Indep, Ind*

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.