

No. 2
-5-43
-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 19 1946 THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27121**
Registrar's No. **3410**

Registration District No. **149** Primary Registration District No. **10.02**

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: **3031 Troost**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **XX**
In this community **60 yrs**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson** **48**
(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **3031 Troost** **8**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No) **11**
If yes, name country

3. (a) PRINT FULL NAME **Mrs. Marcella Emma Fleming**
(b) If veteran, name war **XX no**
(c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **5**
year **1946** hour **10:** minute **40** P. M.

4. Sex **Fe** / 5. Color or race **Wh**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Gilbert E. Fleming**
6. (c) Age of husband or wife if alive **XX** years
7. Birth date of deceased **October 23 1852**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb 21** 19**43** to **Aug 5** 19**46**
that I last saw him alive on **Aug 5** 19**46**
and that death occurred on the date and hour stated above.

8. AGE: Years **94** Months **9** Days **12**
If less than one day hr. min.

Immediate cause of death **Myocardial Infarction**
Due to **Senility**

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

Other conditions (Include pregnancy within 3 months of death)
Major findings: **9-2-46**
Of operations
Of autopsy

MOTHER FATHER {
11. Industry or business
12. Name **No Record** **9**
13. Birthplace **" "** (City, town, or county) (State or foreign country) **9**
14. Maiden name **No Record**
15. Birthplace **" "** (City, town, or county) (State or foreign country) **9**

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Charles S. Metzler**
(b) Address **5519 Rockhill Road**
17. (a) **Burial** (b) Date thereof **8-8-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Forest Hill**
18. (a) Signature of funeral director **J. H. Wagner**
(b) Address **Kansas City, Mo.**
19. (a) **8-8-46** (b) **St. 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) (e) Means of injury **0**
23. Signature **Carol Jackson** (M. D. or other) **0**
Address **1103 1/2 1st St** Date signed **8-6-46**

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address..... *Kansas City, 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.