

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **22** Primary Registration District No. **5289**

1. PLACE OF DEATH:
(a) County **Clay**
(b) City or town **Galliton Twp.**
(c) Name of hospital or institution: **No**
(d) Length of stay: In hospital or institution. **58 Years**
In this community **58 Years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Clay**
(c) City or town **2801 East 42 St.**
(d) Street No. **North Kansas City Mo**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Florida DeMotte**
(b) If veteran, name war **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **18** year **1946** hour **I.** minute **30** P. M.

3. (c) Social Security No. **No**
4. Sex **Female** Color or race **Wh.**
5. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Samuel**
(c) Age of husband or wife if alive **77** years
7. Birth date of deceased **Dec. 7 1871**

21. I hereby certify that I attended the deceased from **Sept. 18** to **Nov. 18** 19**46** that I last saw her alive on **Nov. 12** 19**46** and that death occurred on the date and hour stated above.

8. AGE: Years **74** Months **II** Days **II** If less than one day hr. min.

Immediate cause of death **Chronic myocarditis - Sclerosis - Generalized**
Due to.....
Due to.....

9. Birthplace **Oseola Mo**
10. Usual occupation **Housewife**

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **93D**
Of autopsy.....

11. Industry or business
12. Name **William Williamson**
13. Birthplace **No Record**
14. Maiden name **Sarah Schmuck**
15. Birthplace **Ohio**

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

16. (a) Informant **Mr Fred DeMotte**
(b) Address **5717 Swope Park Way Memorial Park**
17. (a) **Memorial Park** (b) Date thereof **Nov. 20 46**
(c) Place: burial or cremation **Memorial Park Cem.**
18. (a) Signature of funeral director **Wornall Funeral Home**
(b) Address **7406 Wornall Rd**
19. (a) **Nov 26 46** (b) **Beulah Kitchner**

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?
(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
23. Signature **[Signature]** (M. D. or other)
Date signed **11-20-46**

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

35240

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-2-46

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. 2748,
working under my personal supervision.

Signed Howard J. Rol.

Licensed Embalmer No. 2745

P. O. Address H. C. Mon

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.