

FILED DEC 24 1946

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

40811
State File No. 5171
Registrar's No.

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: 3660 Summit Street, Conv. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution since 12-3-46
(Specify whether years, months or days) 32 years
In this community 32 years

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. Lucerne Hotel
(If rural, give location)
(e) Citizen of foreign country? X no (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 8
year 1946 hour 5:30 minute P. M.
21. I hereby certify that I attended the deceased from Nov 13
16 to Dec 6 1946
that I last saw her alive on Dec 6 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral thrombosis
Duration 1 day

Due to Senility and Chronic Pharyngitis

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

Major findings: g38
Of operations
Of autopsy
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?
(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 [Signature] (M. D. or other)
Address [Address] signed 12-9-46

3. (a) PRINT FULL NAME Miss Ada Reese

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased unknown

8. AGE: Years 89 Months Days If less than one day hr. min.

9. Birthplace: unknown

10. Usual occupation at home

11. Industry or business X

12. Name John A. Reese

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. (a) Informant Mrs. Boyd W. Harwood

(b) Address Woodlea Hotel, Kansas City, Mo.

17. (a) burial (b) Date thereof 12-10-46

(c) Place: burial or cremation E. Clum

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 12-9-46 (b) [Signature]

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

MOTHER FATHER

Dr. John Knight

Prof. Embled

[Faint handwritten notes and scribbles]

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

[Handwritten signature]

Licensed Embalmer No. *1416*

P. O. Address. *K.C. 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.