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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 29 1947
Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 1058
Registrar's No. 137

Primary Registration District No. 1002

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:
5604 TRACY AVENUE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 27 YEARS years, months or days)

3. (a) PRINT FULL NAME MRS. ELIZABETH AGNES DORSEY

3. (b) If veteran, name war. No 3. (c) Social Security No. NO A.E.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife ALLEN E. DORSEY 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPTEMBER 3 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 5 If less than one day, hr. _____ min. _____

9. Birthplace REONUR IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JOSEPH REHART

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

14. Maiden name ELIZABETH

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

16. (a) Informant MRS. P. D. LYNCH

(b) Address 5604 TRACY AVENUE

17. (a) BURIAL (b) Date thereof JAN-11-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director W. J. Newcomer

(b) Address 1404 Bush Creek Blvd.

19. (a) 1-11-47 (b) Steraldine Holmes
(Date received local registrar) (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. 5604 TRACY AVENUE
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 8
year 1947 hour 6 minute 40 M.

21. I hereby certify that I attended the deceased from Jan 5 to Jan 7
that I last saw him alive on Jan 7 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Duration 3 days

Due to asthma

Due to _____

Other conditions (Include pregnancy within 3 months of death) 935

Major findings: Of operations no

Of autopsy no

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 _____ (Specify type of place) Means of injury _____

23. Signature John T. Schuman (M. D. or other) MD
Address 1162 Grand Ave Date signed 1-9-47

Original Aug 01 1910

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 *Paul Fapp*

Licensed Embalmer No. *3458*

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.