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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9106**
Registrar's No. **1187**

Registration District No. **149** 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
(c) Name of hospital or institution:
3423 Euclid /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community 25 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Elizabeth C. HALL
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex female / 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife James W. Hall
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November 6, 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>4</u>	<u>8</u>	hr. min.

9. Birthplace Vincennes, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business ---

MOTHER FATHER

12. Name Louis Lahue
13. Birthplace Unknown
(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 Mrs. C. E. Testorff
(b) Address 3423 Euclid Ave., K.C., Mo.
17. (a) Removal (b) Date thereof 3-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hallsville, Mo.

18. (a) Signature of funeral director Melody-McGilley-Eyler
(b) Address Kansas City, Missouri
19. (a) 3-15-47 (b) Sheldine 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. 3423 Euclid
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar. day 14
year 1947 hour 3 minute 55 P. M.
21. I hereby certify that I attended the deceased from 7 to 1947
19 to 7 March 1947
that I last saw her alive on 7 March 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
myocarditis chronic
Chronic Bright's Disease
Due to _____

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

Major findings: 1318
Of operations _____
Of autopsy _____

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? 0

23. Signature H. E. Lehigh (M. D. or other) MD
Address Overland Park Kc Date signed 15 March 1947

Dr. Leigh
8024 Santa Fe
Overland Park,
Kans. 1:30 Sat.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.