V. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1947

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

9148

State File No.

Registrar's No. 1211

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: 235 Ward Parkway
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or Institution: no. (Specify whether years, months or days)

In this community: 31 years

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.: 235 Ward Parkway 8
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No) 0

If yes, name country: x

3. (a) PRINT FULL NAME: Mrs. Bessie ~~Dalzell~~ Hoyland

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: widowed

6. (b) Name of husband or wife: George W. Hoyland

6. (c) Age of husband or wife if alive: unknown years

7. Birth date of deceased: November (Month) 3 (Day) 1879 (Year)

8. AGE:

Years	Months	Days	If less than one day
67	4	12	hr. min.

9. Birthplace: Pennsylvania (City, town, or county) (State or foreign country)

10. Usual occupation: at home,

11. Industry or business: x

FATHER
12. Name: Samuel Martin Dalzell
13. Birthplace: Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Eleanor King
15. Birthplace: Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant: Samuel D. Hoyland
(b) Address: Osceola, Iowa,

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 3-17-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill Cemetery

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

19. (a) 3-17-47 (Date received local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15 year 1947 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from October 1 1946 to March 15 1947 that I last saw him alive on March 14, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: acute coronary occlusion	5 days
Due to: Generalized arteriosclerosis	2 yrs
Due to: Chronic myocarditis	2 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: none	
Of autopsy: none	

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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature: Cabray Wortley, M.D. (M. D. or other) M.D.
Address: 415 Corby Bldg. Date signed 3-16-47
St. Joseph, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Robert H Reed

Licensed Embalmer No. 374 S

P. O. Address Ke. 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.