

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13390

FILED MAY 5 1947  
Registration District No. 1047

Primary Registration District No. 1001

Registrar's No. 1817

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

1. PLACE OF DEATH: Jackson  
 (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 General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
 In this community unknown  
 years, months or days (Specify whether)

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. 2509 Troost  
 (If rural, give location)  
 (e) Citizen of foreign country? no. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jennie Carroll  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month April day 22  
 year 1947 hour 1 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from April 16 1947 to April 22 1947  
 that I last saw her alive on April 22 1947  
 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color of race WHITE  
 6. (a) Single, widowed, married, divorced WIDOWED  
 6. (b) Name of husband or wife unknown  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Feb. 13 1871  
 (Month) (Day) (Year)

Immediate cause of death Cardiac decompensation  
 Duration \_\_\_\_\_

8. AGE: Years 76 Months 2 Days 9  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) IC  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy None

9. Birthplace PLATTE Co. Mo.  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation NONE

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

11. Industry or business \_\_\_\_\_  
 12. Name UNKNOWN  
 13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)  
 14. Maiden name UNKNOWN  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. E. Taylor  
 (b) Address 4102 Euclid, Kansas City, Mo.  
 17. (a) BURIAL (b) Date thereof 4-24-47  
 (Burial, cremation, or removal) (City or town) (Day) (Year)  
 (c) Place: burial or cremation Union Truist Cem. Edgerton Mo.  
 18. (a) Signature of funeral director Gallung - Nash  
 (b) Address Edgerton Mo.  
 19. (a) 4-22-47 (b) Geraldine Holmes  
 (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_  
 23. Signature Wm W. Hart (M. D. or other) \_\_\_\_\_  
 Address Med. Dir. Gen'l Hosp. Date signed 4-22-47

*Dr. Schuyler*

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**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..... *Virian R. Nash* .....

Licensed Embalmer No. *3947* .....

P. O. Address..... *Salisbury, 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.**