No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17662

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2183

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: Wheatley Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-29-47-5-15-47 (Specify whether
In this community about 53 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson 48
(c) City or town ~~406 E. Pacific St.~~ Indep. Mo. 4
(If outside city or town limits, write "RURAL")
(d) Street No. 406 E. Pacific St. 4
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

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

4. Sex Female 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife unk. Deceased
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 29. (Month) (Day) (Year)

8. AGE: Years About 53 yrs | Months — | Days — | If less than one day hr. min.

9. Birthplace Independence Mo (City, town, or county) (State or foreign country)
10. Usual occupation General Housework
11. Industry or business
FATHER
12. Name William Hudson
13. Birthplace Unknown Kentucky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Louisa Meadows
15. Birthplace Independence Mo (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Sousie Hudson Oates
(b) Address 719 E. Pacific St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn, Indep. Mo.
18. (a) Signature of funeral director C. E. Davis
(b) Address K. C. Mo.
19. (a) 5-17-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 15 year 47 hour 2 minute P M.
21. I hereby certify that I attended the deceased from 4-28-47 to 5-15-47, 1947; that I last saw her alive on May 14, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Thrombosis	
Due to Cerebral Arterio-Sclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: 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? (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 [signature] (M. D. ~~or other~~)
Address 1830 Vine Date signed 5-15-47

(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 L. L. Davis

Licensed Embalmer No. 4417

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.