

S. No. 2
DM-5-43
v. 5-17-39
X36671

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**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Osteopathic Hospo O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day**
1 yr. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Wagoner**

(c) City or town **Kansas City, Kansas**
(If outside city or town limits, write "RURAL")

(d) Street No. **658** **Main**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Jeanette Mon K. NAIL**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **None**

4. Sex **Fe** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Harry D. Nail**

6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **1-23-1881**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **17**
year **1947** hour **9** minute **20** P.M.

21. I hereby certify that I attended the deceased from **May-18**
1947 to **June-17**, 1947;
that I last saw her alive on **June-17**, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Duration **10 min**

8. AGE: Years Months Days If less than one day

66 **4** **24** hr. min.

Due to **Hypertensive-Cardio-Vascular-Renal Syndrome**

Due to _____

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

10. Usual occupation **Housewife**

Other conditions (include pregnancy within 3 months of death) **131a**

11. Industry or business _____

12. Name **Howard Motok**

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

14. Maiden name **no record**

15. Birthplace **no record**
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy **Coronary Occlusion**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. H. M. Flanagan**

(b) Address **242 Madison - Jeanette City, Ill.**

17. (a) **Removed** (b) Date thereof **6-18-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Janite City, Illinois**

18. (c) Signature of funeral director **Mrs. C. R. Foster**

(b) Address **918 Brooklyn**

19. (a) **6-19-47** (b) **Geraldine Helmer**
(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury **2**

23. Signature **F. W. Thompson** (M. D. or other) **DO.**

Address **105-10 Bryant Bldg - K.C. Mo** Date signed **6-17-47**

Dr. Fred Thompson
Buy out 13/2/59
Pr 2462

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.....

working under my personal supervision.

Jerry A. Meier

Registered Apprentice No. *437*

Signed *Orlando Meier*

Licensed Embalmer No. *3484*

P. O. Address *18 Broadway*

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.