

FILED JUN 30 1947

State File No. ....

Registration District No. 15247

Primary Registration District No. 5574

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Jackson - Rural Washington Missouri  
(b) City or town Jackson City - RURAL  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Residence - 102ND BLUE RIDGE  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community 50 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) County Jackson 48  
(b) City or town Jackson City - RURAL  
(If outside city or town limits, write "RURAL")  
(c) Street No. 102<sup>ND</sup> Blue Ridge  
(If rural, give location)  
(d) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

MRS GENEVIEVE ESTHER DIERS

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18<sup>TH</sup>  
year 1947 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from June 17<sup>th</sup> to June 18<sup>th</sup>, 1947  
that I last saw him alive on June 18<sup>th</sup>, 1947  
and that death occurred on the date and hour stated above.  
Duration

Immediate cause of death Coronary Thrombosis Two days

8. AGE: Years 67 Months 8 Days 1 If less than one day hr. min.

Due to Hypertension + Arteriosclerosis ?

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

Due to

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business Housewife

Major findings: Of operations

12. Name William Mackay

Of autopsy

13. Birthplace Unknown Canada (City, town, or county) (State or foreign country)

14. Maiden name Martha Cristy

15. Birthplace Philadelphia Pa. (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Frank O. Diers, Jr.

(b) Address 102<sup>ND</sup> Blue Ridge

17. (a) Burial or removal Cremation (b) Date thereof June 20, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation D.W. Newcomers Sons Home

18. (a) Signature of funeral director D.W. Newcomers Sons

(b) Address Kansas City, Missouri

19. (a) Date received local registrar 6/20/47 (b) Anne H. Hedger (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 B.L. Must D.O. (M. D. or other) W.O.

Address RFD #7 Grandview, Mo Date signed 6-19-47

MOTHER FATHER

PHYSICIAN

Underline the cause of which death should be charged statistically.

JUL 8 194

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 *D. D. Nofsinger*  
Licensed Embalmer No. *3938*  
P. O. Address *Kansas City*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 19

Registration District No. 154

Primary Registration District No. 5571

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Genevieve E. Diers

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Oct 17 (Month) (Day) (Year)

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town or county) (State or foreign country) Penn

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) June 20-1947 (b) Dr Annie G. Bridges  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY 18

S-2131D