

No. 2
-12-45
5-17-39
X 47070

FILED JUL 3 1947

Registration District No. **15-2**

Primary Registration District No. **15-5-22**

Registrar's No. **106**

1. PLACE OF DEATH:

(a) County **JACKSON**

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

(c) Name of hospital or institution:
1/2 mi S.W. Greenwood Mo /
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

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

(d) Street No. **1/2 mi S.W. of Greenwood**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **NARCISSUS E. ELSWICK**

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 **JG. ELSWICK**

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

7. Birth date of deceased **MAY 15 1890**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26**
year **1947** hour **8:15** minute **A** M.

21. I hereby certify that I attended the deceased from **May 13 1947** to **June 26 1947**
that I last saw her alive on **June 26 1947**
and that death occurred on the date and hour stated above.

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| 77 | 1 | 11 | hr. min. |

Immediate cause of death **Chronic myocarditis** **1 yr**

Due to **Fracture of right femur** **1 month**

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Housewife**

11. Industry or business **Unknown**

Major findings:
Of operations **186A**

Of autopsy **18**

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

MOTHER FATHER

12. Name **David Greene** **9**

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

14. Maiden name **MARY FRANCIS ROSE** **9**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Emma Kroinick**

(b) Address **Greenwood Mo**

17. (a) **Removal** (b) Date thereof **6-28-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Guyton Okla**

18. (a) Signature of funeral director **W. B. Langford**

(b) Address **Lees Summit Mo**

19. (a) **6-28-47** (b) **Donald C. Emshorn**
(Date received local registrar) (Registrar's signature) **378**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Fell in her home**

(b) Date of occurrence **May 13 1947** **49**

(c) Where did injury occur? **Lees Summit Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home, slipped on floor
(Specify type of place)

While at work? **No** (e) Means of injury **①**

23. Signature **Clint A. Miller** (M. D. or other) **740**

Address **Lees Summit Mo** Date signed **6-26-47**

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

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 T. B. Langford
Licensed Embalmer No. 3233

P. O. Address Fair Summit

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.