

S. No. 2
M-5-43
5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24215**
Registrar's No. **3005**

FILED AUG 5 1947
Registration District No. **149**

Primary Registration District No. **1002**

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: **General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 hrs.**
In this community **35 Years**
years, months or days

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. **927 Locust**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Nellie Henderson**
(b) If veteran, **no** name war
(c) Social Security No. **496-24-0252**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **13**
year **1947** hour **11** minute **15** P. M.

4. Sex **F** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **William Henderson**
6. (c) Age of husband or wife if alive **1893** years
7. Birth date of deceased **Oct. 3, 1947**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 13, 1947** to **July 13, 1947**
that I last saw her alive on **7-13** and that death occurred on the date and hour stated above.

8. AGE: Years **53** Months **9** Days **10**
If less than one day
.....hr.min.

Immediate cause of death
Carcinoma of splenic flexure
Generalized peritonitis
Splenic and hepatic abscess

9. Birthplace **Clinton, Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Due to
Other conditions (Include pregnancy within 3 months of death)
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MOTHER FATHER
11. Industry or business
12. Name **James H Wells**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Ella Josephine Gowen**
15. Birthplace **Ill.**
(City, town, or county) (State or foreign country)

Major findings:
Of operations
Of autopsy **See above**
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Howard Wells**
(b) Address **927 Locust**
17. (a) **Burial** (b) Date thereof **7/17/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenlawn**
18. (a) Signature of funeral director **Passantino Bros**
(b) Address **2117 Indep. Blvd.**
19. (a) **7-16-47** (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?
While at work? (Specify type of place) (c) Means of injury
23. Signature **Wm W Hart** (M. D. or other) **MD**
Address **Med. Dir. Gen'l Hosp.** Date signed **7-14-47**

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

Dr. Hebbard

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 *Francis Walter*.....

Licensed Embalmer No. *2744*.....

P. O. Address.....

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.