

No. 2
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17-39

27575

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 26 1947

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3420**

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:
3426 MORRELL AVENUE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community **6 YEARS**

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON** **48**
(c) City or town **KANSAS CITY** **3**
(If outside city or town limits, write "RURAL.")
(d) Street No. **3426 MORRELL AVENUE** **8**
(If rural, give location) **6**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **NANCY EMMA BAXTER**
3. (b) If veteran name war **No**
3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **AUGUST** day **11** 1947
year **1947** hour **9** minute **10 A.** M.
21. I hereby certify that I attended the deceased from **8-8-47**
_____ 19____ to **8-11-** 19**47**
that I last saw her alive on **8-11-** 19**47**
and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **MRS. LACHRA M. BAXTER** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JANUARY-16-1858**
(Month) (Day) (Year)

Immediate cause of death **Cerebral hemorrhage - extreme hypertension**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **89** Months **6** Days **25**
If less than one day _____ hr. _____ min.

Major findings: Of operations **g23**
Of autopsy _____
PHYSICIAN _____
Underline the cause of which death should be charged statistically.

9. Birthplace **OSAGE COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____
12. Name **KATHARINE HILL**
13. Birthplace **UNKNOWN MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **L. J. HILL**
15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. J. R. Canton**
(b) Address **3426 MORRELL AVENUE**

17. (a) **removal** (b) Date thereof **aug 11/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Louis Mo.**

18. (a) Signature of funeral director **Dr. Nuscomer**
(b) Address **1401 Brushy Creek Rd Mo**

19. (a) **8-11-47** (b) **Sheldine 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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature **Earl V. Jones** (M. D. or other) **Dr**
Address **100 1/2 S. Ash** Date signed **8-11-47**

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

9:45 a.m.

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..... *E. Oscar Northey*
Licensed Embalmer No. *1767*
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.