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FILED SEP 11 1947

Registration District No. 176

Primary Registration District No. 5568

Registrar's No. 268

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence Rural Blue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
11308 East 14th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 43 Years
(Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME ALICE JANE DONALDSON

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William F. Donaldson 6. (c) Age of husband or wife if alive 91 years

7. Birth date of deceased July 3 1850
(Month) (Day) (Year)

8. AGE: Years 91 Months 1 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name John N. Willett

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

14. Maiden name Sarah Thompson

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

16. (a) Informant Bartha L. Wader

(b) Address 11308 East 14th

17. (a) Burial (b) Date thereof 9-3-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Grove Cem.

18. (a) Signature of funeral director Robert L. Taylor
(b) Address Independence, Missouri

19. (a) 9-3-47 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Independence Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 11308 East 14th 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 1st
year 1947 hour 3 minute 15 p.m.

21. I hereby certify that I attended the deceased from Sept 27 1947 to Sept 1 1947
that I last saw her alive on Aug 28 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis
Duration _____

Due to General Arterio-Sclerosis, Sensibility & myocardial
Due to _____

Other conditions Fractured hip at 1946
(Include pregnancy within 3 months of death)
April 6, 1947

Major findings: Fracture of humeral shaft
Of operations Fracture of humeral shaft
Of autopsy None

22. If death was due to external causes, fill in the following: 48
(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?

23. Signature Carl Allen M.D. M. D. or other _____
Address Independence Date signed 9/2/47

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

OCT 21 1947

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 Dillon L. Kopke

Licensed Embalmer No. 4225
P. O. Address Independence, Mo.

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

28045
Sept
State File No.
Registrar's No.

Registration District No. Primary Registration District No. 5568

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Independence
(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 Alice Donaldson
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, man
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 9=1 Months Days 2=3 If less than one day hr. min.

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

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)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (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 day year hour minute M.
21. I hereby certify that I attended the deceased from that I last saw him alive on and that death occurred on the date and hour stated above.

Duration
Immediate cause of death
Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

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

(b) Date of occurrence April 7, 1947

(c) Where did injury occur? home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home-residence

While at work no (Specify type of place) fractured hip (e) Means of injury

23. Signature C. F. Allen (M. D. or other)

Address Independence Date signed Oct 29/47

SUPPLEMENTARY

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

MOTHER FATHER

C.H. Allen MD

Independent MD