

No. 300  
1-10-47  
5-17-39  
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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED MAY 15 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12566  
Registrar's No. 1905

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
623 E. 6th St. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 54 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 48  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 623 E. 6th St. 8  
(If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME OLIVIA BELL FRANCE

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 2-48  
year 1948 hour 10:48 AM

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to 5/3/48 19\_\_\_\_

that I last saw her alive on 5/2/48 19\_\_\_\_ and that death occurred on the date and hour stated above.

4. Sex Fe 5. Color or race col

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife: MERMON B France

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased unknown  
(Month) (Day) (Year)

Immediate cause of death: Acute myocarditis Duration \_\_\_\_\_

Due to obscure

8. AGE: Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

Other conditions no no  
(Include pregnancy within 3 months of death)

9. Birthplace Mississippi 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Major findings: None 930

Of operations \_\_\_\_\_

Of autopsy no

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

12. Name unknown 9

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 Mrs. Josephine Scott

(b) Address 2044 Bellevue

17. (a) Burial (b) Date thereof 5-6-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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? no

While at work? no (Specify type of place) (e) Causes of injury no

23. Signature Henry B. Lynam M.D. (or other) \_\_\_\_\_

Address 1605 - 8th St Date signed 5/3/48

18. (a) Signature of funeral director H.B. Moore

(b) Address 1820 East 18 St

19. (a) 5-3-48 (b) Stardline Holman  
(Date received local registrar) (Registrar's signature)

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**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 HB Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E 18th

**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.**