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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12737

State File No. \_\_\_\_\_

FILED MAY 15 1948

Registrar's No. 1926

Registration District No. 749

Primary Registration District No. 1002

48  
3  
8  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:  
ST. LUKES HOSP. 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 DAYS  
(Specify whether years, months or days)  
In this community 63 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County JACKSON 48  
(c) City or town KANSAS CITY 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. BROOKSIDE HOTEL 8  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MR. CHAS. H.R. MCELROY

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife SARAH MCELROY 6. (c) Age of husband or wife if alive unk. years  
7. Birth date of deceased OCT. 4 1863  
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation REAL ESTATE

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

12. Name CHAS. K.R. MCELROY

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

14. Maiden name MARY SHUCK (State or foreign country)

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

16. (a) Informant MR. NATHAN BUZBY

(b) Address BROOKSIDE HOTEL

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-11-48  
(Month) (Day) (Year)

(c) Place: burial or cremation LEXINGTON, KY.

18. (a) Signature of funeral director STINE & MCCLURE

(b) Address KANSAS CITY, MO.

19. (a) 5-4-48 (Date received local registrar) (b) Thereldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Apr 14 1948, to May 2 1948 that I last saw him alive on May 2 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

Due to Atherosclerosis

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

Other conditions 137a  
(Include pregnancy within 3 months of death)

Major findings: Of operations Prostatic hypertrophy

Of autopsy no PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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 Edo J. Oberlander (M. D. or other) \_\_\_\_\_

Address 411 Alameda Rd K.C. Mo Date signed 5/3/1948

**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..... *Robert H Reed* .....

Licensed Embalmer No. *3745* .....

P. O. Address..... *H. C. 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.