

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUN 26 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19498
2510
Registrar's No. _____

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
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital K.C. Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days
(Specify whether _____)

In this community 20 years
years, months or days

3. (a) PRINT FULL NAME Mae Hartsell

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased 5 (Month) 27 (Day) 1870 (Year)

8. AGE: Years 78 Months 0 Days 8 If less than one day hr. _____ min. _____

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name unknown 9

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

14. Maiden name unknown

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

16. (a) Informant Record Clerk

(b) Address 55 E. Du Sable 1st

17. (a) burial (b) Date thereof 6-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deeds

18. (a) Signature of funeral director Wm. A. Schaefer

(b) Address City, Missouri

19. (a) 6-15-48 (b) Heraldine Helber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 18

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

(d) Street No. 908 Independence Avenue 8
(If rural, give location)

(e) Citizen of foreign country? unknown (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29th
year 1948 hour 2 minute 27P P.M.

21. I hereby certify that I attended the deceased from 5-15-48, 19, to 5-29-48, 19;
that I last saw her alive on 5-29-48, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 830 PHYSICIAN _____
Of operations _____
None
Of autopsy _____
None

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) (e) Means of injury 0

23. Signature Wm. W. Hest (M. D. or other) MD
Address Ed. Dir. K.C. Gen. Hospital K.C. Mo. Date signed _____

A. P. Jones

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..... *Wm. A. Johnson*

Licensed Embalmer No..... *3089*

P. O. Address..... *ITC MD*

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.