

No. 300
-10-47
5-17-39
P1 3908

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26410**
Registrar's No. **3421**

FILED SEP 4 1948
Registration District No. **49**

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
1918 E. 24th - St. Penace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **10 years** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City, Mo.** 48
(If outside city or town limits, write "RURAL")
(d) Street No. **1918 E 24th Ave.** 3
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME **Mary Jane Kelgore**
(b) If veteran, name war **no**
(c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **19** - 1948
year **48** hour **5:30** AM minute **0** M.
21. I hereby certify that I attended the deceased from **Aug 16**
sixteenth 148 to **Aug. 16** 1948
that I last saw her or alive on **Aug. 16** 1948
and that death occurred on the date and hour stated above.

4. Sex **Fe** 3
5. Color or race **Bl**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **unknown**
6. (c) Age of husband or wife if alive **25** years
7. Birth date of deceased **Dec 25 1869**
(Month) (Day) (Year)

Immediate cause of death **Cachexia and Terminal Bronchopneumonia** Duration
Arteriosclerotic Heart Disease.

8. AGE: Years **80** Months **7** Days **24** If less than one day
hr. min.

Due to **Arteriosclerotic Heart Disease.**
Due to **None**
Other conditions **None**
(Include pregnancy within 3 months of death)

9. Birthplace **South Carolina** 1
(City, town, or county) (State or foreign country)
10. Usual occupation **at home**

Major findings: **None** 93.8
Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business
12. Name **Primus Aaron**
13. Birthplace **So Carolina** 1
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Melian Dupree**
(b) Address **1918 E 24th Ave.**
17. (a) **Lincoln** (b) Date thereof **8-24-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation **Lincoln**
18. (a) Signature of funeral director **Harvey Bros.**
(b) Address **2304 Vine St.**
19. (a) **8-21-48** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

While at work (Specify type of place) (e) Manner of injury
Signature **George H. Hoff** M.D.
Address **2204 E. 18th st.** Date signed **8/20/48**

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

W. H. Abraham

Licensed Embalmer No. *2549*

P. O. Address *2304 West*

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.