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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 4 1948

Registration District No. 749

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 36446

Registrar's No. 4677

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town K.C. MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 806 ~~[illegible]~~ TERR Greenway Terrace 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 23 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County JACKSON 48

(c) City or town KANSAS CITY, MO. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2506 TRACY 8
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME CORNELIA CLAYTON

3. (b) If veteran, name war NONE

3. (c) Social Security No. 492-26-0746

4. Sex FE 3

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife NONE unknown

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

7. Birth date of deceased JAN (Month) 1 (Day) 1873 (Year)

8. AGE: Years 75 | Months 10 | Days 11 | If less than one day ..... hr. ..... min.

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

10. Usual occupation CATERESS

11. Industry or business .....

FATHER
12. Name AL. TODD
13. Birthplace ..... (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name ELVIRA CAMPBELL
15. Birthplace ..... (City, town, or county) MO (State or foreign country)

16. (a) Informant Ernest Clayton
(b) Address 2506 Tracy K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-48 (Month) (Day) (Year)
(c) Place: burial or cremation Highland K.C. Mo

18. (a) Signature of funeral director Flynn & Greensheel
(b) Address 1819 E. 15 K.C. Mo

19. (a) 11-16-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 12
year 1948 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from ..... 19.... to ..... 19....;
that I last saw h..... alive on ..... 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Due to Hypertensive Heart Disease

Due to .....

Other conditions Facial Paralysis
(Include pregnancy within 3 months of death)

Major findings:
Of operations 93 ♂

Of autopsy No-Permit

Duration

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? .....
(Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature J. R. Williams (M. D. or other) J. R. Williams

Address 2636-Brooklyn Date signed 11-16-48

(Licensed Embalmer's Statement on Reverse Side)

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. G. Flynn

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th K.C.M

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.