

No. 300
10-47
5-17-39
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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED NOV 16 1948

Registration District No. 799

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 36603

Registrar's No. 4404

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:
In Park at 9th & Summit 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 about 5 months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. Coates House: 10th & Broadway
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Edsel Herring

3. (b) If veteran, name war W. W. I

3. (c) Social Security No. Unknown

4. Sex Male 2

5. Color or race White

6. (a) Single, widowed, married, divorced Single 1

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Feb. 23 1926
(Month) (Day) (Year)

8. AGE: Years 22 Months 10 Days 8 5

If less than one day hr. _____ min. _____

9. Birthplace Miss. 10
(City, town, or county) (State or foreign country)

10. Usual occupation Draftsman

11. Industry or business Greenwoods Inc.

12. Name Will J. Herring

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

14. Maiden name Clarabelle Brazewell 9

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

16. (a) Informant Investigation

(b) Address Coroner's Office

17. (a) Removal (b) Date thereof 10-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winona, Miss.

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address 2332 Monitor Place: K.C. Mo.

19. (a) 10-29-48 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28th
year 1948 hour 4:10PM minute _____ 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 Cerebratory Failure Duration _____

Due to Barbituric acid intoxication

Due to 103.B

Other conditions Deputy Coroner
(Include pregnancy within 3 months of death)

Major findings: See Above PHYSICIAN

Of operations _____

Of autopsy See Above

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) suicide

(b) Date of occurrence 10-28-48

(c) Where did injury occur? K.C. Jackson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
A. E. Upsher

While at work Public Place
(Specify type of work) (Specify means of injury)

23. Signature D. E. Upsher (M. Registrar)

Address 2800 Main 10/29/48

NOV 9 1981

1981

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..... *Blaine E. Weichert*

Licensed Embalmer No. *4075*

P. O. Address..... *K.C. 8, 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.

No. 2B
13-45
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 20 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 100
Registrar's No. 4404

Registration District No. 117

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Elsel Herring

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

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

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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 _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-29-48 (Date received local registrar) (b) Seraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 1948 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Cross out circulatory failure appearing on this record.

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

5-36603