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UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36881**
Registrar's No. **4614**

FILED DEC 4 1948

Registration District No. **149** Primary Registration District No. **1002**

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. Gen. Hospital No. 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days** (Specify whether
In this community **50 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

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

(d) Street No. **6003 East 11th St.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **Elizabeth Slade**

3. (b) If veteran, name war. _____ 3. (c) Social Security No. **487-05-7114**

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

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

7. Birth date of deceased **unknown**
(Month) (Day) (Year)

8. AGE: Years **75** Months **-** Days **-** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Slade**

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

14. Maiden name **unkn**

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

16. (a) Informant **Mrs. Wilma Hendrich**

(b) Address **6003 E 11th**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11 12 48** (Month) (Day) (Year)

(c) Place: burial or cremation **Int: Washington**

18. (a) Signature of funeral director **[Signature]**

(b) Address **660 Dundee Ave**

19. (a) **11-11-48** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **10th**
year **1948** hour **8** minute **20** A. M.

21. I hereby certify that I attended the deceased from **11-6-48**, 19____, to **11-10-48**, 19____, that I last saw her alive on **11-10-48**, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac decompensation, Hypertension**

Due to _____

Due to _____

Other conditions **950**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **See above**

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? **Wm. W. Hart** (Specify type of place)

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

Signature **Wm. W. Hart** (M. D. or other) **[Signature]**
Address **Med. Dir. K.C. Gen. Hospital K.C. Mo** Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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.....

J. B. Sheil

Licensed Embalmer No. *3625*

P. O. Address *K. 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.