

FILED JUN 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15844
2233

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY JACKSON	
b. CITY OR TOWN KANSAS CITY	c. LENGTH OF STAY (In this place) 50 YRS.	c. CITY OR TOWN KANSAS CITY	503
d. FULL NAME OF HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSPITAL		d. STREET ADDRESS 218 E 34TH TERRACE	

3. NAME OF DECEASED (Type or Print) a. (First) JAMES		b. (Middle)	c. (Last) ENNIS	4. DATE OF DEATH (Month) (Day) (Year) MAY 23 1949		
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE ()	8. DATE OF BIRTH NOV. 4, 1979	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
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13a. FATHER'S NAME THOMAS ENNIS		13b. MOTHER'S MAIDEN NAME ANN MENOWN		14. NAME OF HUSBAND OR WIFE NONE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME ADDRESS FRANK ENNIS 3227 BELL FOUNTAIN			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Constrictive Pericarditis				
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
II. OTHER SIGNIFICANT CONDITIONS Chronic Fibrous Tuberculosis, bilateral (?)				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION CASE		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Pathologist**, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Jack H. Hill (Degree or title) Jack H. Hill M.D.		23b. ADDRESS Trinity Lutheran Hosp.	23c. DATE SIGNED 22 May 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	24b. DATE 5-24-49	24c. NAME OF CEMETERY OR CREMATORY FOREST HILL	24d. LOCATION (City, town, or county) (State) KANSAS C.T.Y., MO
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DATE REC'D BY LOCAL REG. 5-23-49	REGISTRAR'S SIGNATURE Stardine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SPINET McCLORE K.C. Mo.	
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WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Robert H. Reed

Licensed Embalmer No. *3245*

P. O. Address *K. C. Ind*

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.