

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19479  
2291  
Registrar's No. 2291

FILED JUN 25 1945

Registration District No. 149

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:  
(Home) 4802 E. 7th. St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 38 years (Specify whether 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. 4802 East 7th. St.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Almeda M. Etter

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 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 Dec. 4th. 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>5</u>	<u>29</u>	hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William H. Etter

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

14. Maiden name Phoebe Hollopeter

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

16. (a) Informant Mrs. Lydia Heuelsen

(b) Address 710 Brighton, K.C. Mo.

17. (a) Burial (b) Date thereof 6/5/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deepwater Missouri

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

(b) Address 4139 East 15th. St. K.C. Mo.

19. (a) 6-4-45 (b) Steraldine Holman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3rd.  
year 1945 hour 2 minute 05 P.M.

21. I hereby certify that I attended the deceased from June 3 1945 to June 3 1945 that I last saw her alive on June 3 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemol.  
Diabetes Mellitus  
Hypertension  
Due to \_\_\_\_\_  
Duration 1 day  
6 yrs  
3 yrs

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 6/1

Of autopsy \_\_\_\_\_

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)  
(c) Means of injury 0  
23. Signature Edonae (M. D. or \_\_\_\_\_)  
Address 615 Arroyo Blvd Date signed 6/4/45

*Am. Association  
of Embalmers*

**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 *John B. [Signature]*  
Licensed Embalmer No. *2955*  
P. O. Address *H.C. [Signature]*

**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.**