

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 4521

Registration District No. 399

Primary Registration District No. 1002

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Manassas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wesley Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether)

In this community 30 years
years, months or days

3. (a) PRINT FULL NAME Grace Candice Atkins

3. (b) If veteran, name war No.

3. (c) Social Security No. 70

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Louis Atkins

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased July 15 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>4</u>	<u>13</u>	hr. min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name Albert E. Carr

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

14. Maiden name Ellen Lincoln

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

16. (a) Informant's own signature Theresa M. Atkins

(b) Address 430 N. Grand

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29-39
(Month) (Day) (Year)

(c) Place: burial or cremation Mt Moriah

18. (a) Signature of funeral director Ott + Mitchell

(b) Address 2100 N. Main St Independence Mo

19. (a) Nov 28 1939 (Date received local registrar) (b) M. M. Groves (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 430 N. Grand
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27
year 1939 hour 10 minute 25 A. M.

21. I hereby certify that I attended the deceased from Nov 19th
1939 to Nov 26th 1939

that I last saw her alive on Nov 26th 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 8 days

Due to General Paralysis 8 days

Due to grip

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? 3

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. M. Agee (M. D. or other) A.O.

Address Independence Mo Date signed 11/29/39

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Henry J. Mitchell
Licensed Embalmer No. 3925
P. O. Address Independence 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, above space should be left blank.