

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2217

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Jackson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Conley Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 25 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Ingleswood, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 8906 Smart Ave (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Ruth Louise Daniels 547

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

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

6. (b) Name of husband or wife Orville Daniels 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased August 26 1914
(Month) (Day) (Year)

8. AGE: Years 25 Months 9 Days 3 If less than one day hr. X min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Robert Lee Klemmer

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

14. Maiden name Fannie Chelau

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

16. (a) Informant Orville Daniels

(b) Address 8906 Smart Ave

17. (a) Burial (b) Date thereof 5-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waterloo, Mo

18. (a) Signature of funeral director John P. Sheel

(b) Address 6606 Undergill

19. (a) May 30, 1940 (b) M. R. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1940 hour 9 minute 26 P. M.

21. I hereby certify that I attended the deceased from April 8, 1942, to May 29, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
compensated Duration 2 weeks

Due to Lobar pneumonia 4 weeks

Due to chronic bacillary dysentery
and recurring appendicitis several months

Other conditions (Neither puerperal or gonococ) 139B

Major findings: 4-15-40 ant smt
Of operations: appendix and bilateral salpingitis
5-24-40 per in plural cavity
Of autopsy: none

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 8

23. Signature Margaret Jones (M. D. or other) P.O.
Address 3620 Taback St. Date signed 5-30-40

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

00400000

Office of the Registrar
1000 W. 37th St.
Tulsa, Okla. 74109

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 Samuel Shal*

..... Licensed Embalmer No.

..... P. O. Address

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.