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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 32201

FILED OCT 18 1940

Registration District No. 398 Primary Registration District No. 5534 Registrar's No. 227

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution: 8920 Roberts
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -- (Specify whether in hospital or institution, or 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, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 8920 Roberts
(If rural, give location)

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

8. (a) PRINT FULL NAME Mrs. Nannie Gertrude Civer

8. (b) If veteran, name war -- 8. (c) Social Security No. --

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced ~~Married~~ Widow

6. (b) Name of husband or wife Robert L. Civer 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased March 23, 1854 (Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 27 If less than one day ____ hr. ____ min.

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

10. Usual occupation Homemaker

11. Industry or business ____

FATHER 12. Name George C. Adamson

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

MOTHER 14. Maiden name Martha Jane Crondiff

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

16. (a) Informant Geo. V. Adamson

(b) Address 8920 Roberts, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23-40 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cem.

18. (a) Signature of funeral director C.H.Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd. K.C.Mo.

19. (a) Sept 23/40 (Date received by registrar) (b) F. L. Cook (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 21, year 1940 hour 6 minute 05 AM.

21. I hereby certify that I attended the deceased from Dec 16 1932 ____, 19__, to Sept 21, 1940 that I last saw her alive on Sept 20, 1940 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 days |
| Due to Cerebral hemorrhage, left sided hemiplegia | 2 |
| Due to Occurred Aug 16 1940 | |
| Other conditions (Include pregnancy within 3 months of death) Chronic Cardio-Vascular renal - & Hypertension | |

Major findings:
Of operations no operation
Of autopsy No 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 No injury

(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? ____ (Specify type of place)

While at work? ____ (c) Means of injury ____

23. Signature Lee Allen (M. D. or other) M.D.

Address Independence, Mo Date signed Sept 23

(Licensed Embalmer's Statement on Reverse Side)

Dr. C. H. Allen

Indep. Mo.

Maple & Ola

**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 H D Blackman

Licensed Embalmer No. 3654

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, above space should be left blank.**