

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37687**
Registrar's No. **4285**

Registration District No. **399**

Registration District No. **1002**

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:
K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 25 years
years, months or days)

8. (a) PRINT FULL NAME OLA EVANS

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 Frank 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Febr 10 (Month) (Day) (Year) 1875

8. AGE: Years 65 Months 9 Days 0 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name William Richards

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

14. Maiden name William Rubston

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

16. (a) Informant Parent Evans

(b) Address 2300 Montgall

17. (a) Removal (b) Date thereof 11-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Hope U.C.P.

18. (a) Signature of funeral director Edna Bern Reinhardt

(b) Address 1416 Spring Ave

19. (a) 11-11-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 2300 Montgall
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10th
year 1940 hour 12 minute 10 A.M. M.

21. I hereby certify that I attended the deceased from 11-3-40, 19 , to 11-10-40, 19 ;
that I last saw h. er alive on 11-10-40, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE

Due to Stroke

Due to

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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) (a) Means of injury !

23. Signature Bruce R. Brown (M. D. or other)

Address Med. Dir. K.C. Gen. Hospital Date signed

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

REC'D DEC 11 1940
REC'D DEC 11 1940

MOTHER FATHER

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 Orville H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Kansas City, Kan.

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.