

FILLED NOV 17 1948
Registration District No. 17948

Primary Registration District No. 30-115277A

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

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Rural Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fishing Creek Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution All of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Clay
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. South of Excelsior Springs 8 mi
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Easter Annie O'Hell

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 30
year 1941 hour 6 minute A M.

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

21. I hereby certify that I attended the deceased from 10-19-41 to 10-30-41, 1941.
that I last saw her alive on 10-30-41 and that death occurred on the date and hour stated above

4. Sex Female 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife J. S. O'Hell 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased: June 17 1872
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Breast Duration 3 1/2 yrs

8. AGE: Years 69 Months 4 Days 13 If less than one day hr. _____ min. _____

Due to _____
Due to 52R

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

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation At home

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Thomas Summers

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

14. Maiden name Sarah Ann Woods

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

16. (a) Informant J. M. O'Hell
(b) Address Excelsior Springs Mo

17. (a) Burial (b) Date thereof 11-10-41
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Eamon
(b) Address Excelsior Springs Mo

19. (a) Oct 31-41 (b) Maude M. Cracker
(Date received local registrar) (Registrar's signature)

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? _____

23. Signature Regina B. ... (M. D. or other) _____
Address Excelsior Springs Mo Date signed 10/21/41

RECEIVED

District Health Officer No. 8,

District File _____

Date Filed 11-12-41

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Spgs, 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, fact should be so stated above.