

No. 2
4-13-40
5-17-39
P-I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37498

State File No. _____

DEC 22 1941 399

Primary Registration District No. 1002

Registrar's No. 4293

488

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

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: Leeds T. B. M. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mos 5 days
(Specify whether)

In this community 16 years
years, months or days

3. (a) PRINT FULL NAME Isabell Cottrell

3. (b) If veteran, name war _____

3. (c) Social Security No. 487-14-4570

4. Sex Female 5. Color or race negro

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

6. (b) Name of husband or wife Wesley Cottrell

6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased may 19 1907
(Month) (Day) (Year)

8. AGE: Years 34 Months 5 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Seamstress

11. Industry or business _____

MOTHER FATHER { 12. Name Felby Foster

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

14. Maiden name Lucy Bander

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

16. (a) Informant Leeds T. B. M. Hospital

(b) Address Leeds Missouri

17. (a) Burial (b) Date thereof 11-21-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation home in

18. (a) Signature of funeral director Adkins Bros.

(b) Address 2000 E. 12th St. Ma

19. (a) 11-19-41 (b) M. M. Crowe
(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. 1019 Base
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 16 year 1941 hour 10 minute 25 P.M.

21. I hereby certify that I attended the deceased from 7-11, 1941, to 11-16, 1941, that I last saw her alive on 11-16, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death pulmonary hemorrhage

Due to Pulmonary tuberculo-
sis

Due to 12 P

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

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) (Means of injury)

23. Signature [Signature] (M. D. or other) _____
Address KC 16 W. 12th St. Mo Date signed 11-16-41

MAR 3 1943

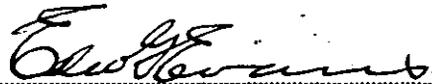
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No.....

3836

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, fact should be so stated above.