

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23601**
Registrar's No. **2991**

FILED AUG 17 1942

Registration District No. **149**

Primary 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:
Died in Ambulance on way to Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community **15 Yrs**
years, months or days (Specify whether)

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. **1344 East 9 St.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Mollie Mildred Shrout**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **Femal** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Robert L Shrout** 6. (c) Age of husband or wife if alive **77** years
7. Birth date of deceased **May 13 1860**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 2 23 hr. min.

9. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business

12. Name **Thomas Gains**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **no record**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert L. Shrout**
(b) Address **1344 East 9 St.**

17. (a) **Burial** (b) Date thereof **Aug 8 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **Blue Springs Mo.**

18. (a) Signature of funeral director **Mrs C. L. Forster**

(b) Address **918 Brooklyn**

19. (a) **8-8-42** (b) **Mr M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **6**
year **1942** hour **6** minute **P** M.

21. I hereby certify that **Dr. Brown** attended the deceased from..... 19.....;
that I last saw him..... alive on..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Primary infection
Due to Biliary obstruction
due to chronic cholecystitis
Due to Post renal TB
Bilateral Hydronephrosis
Other conditions **no other conditions**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **12 P**
Of autopsy **above**

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) Means of injury
23. Signature **Dr. Brown** (M. D. or other)
Address..... Date signed.....

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

480
2000

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed L. H. Wise

Licensed Embalmer No. 2590

P. O. Address Kansas City 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.