. S. No. 2
OM—5-42
ev. 5-17-39
I X32873

48
3
8

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 9 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32702

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3864

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 No.1 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether 41 yrs

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3 8

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 1008 West 37th St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Sophie Elniff

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female 1

5. Color or race W.

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife John.

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

7. Birth date of deceased Aug. (Month) 24th (Day) 1859 (Year)

8. AGE: Years 83 Months 1 Days 21 If less than one day hr. min.

9. Birthplace Denmark (City, town, or county) 4 (State or foreign country)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Hans Hanson
13. Birthplace Denmark (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Regine
15. Birthplace Denmark (City, town, or county) 4 (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K.C.General Hospital

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-20-42 (Month) (Day) (Year)

(c) Place: burial or cremation MT. WASHINGTON

18. (a) Signature of funeral director MELLODY. M'CILLETT

(b) Address K.C. MO.

19. (a) 10-20-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15th year 1942 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from 10-7-42, 19, to 10-15-42, 19; that I last saw her alive on 10-15-42, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of right femur due to accidental fall in home; Arteriosclerotic heart disease

Due to

Due to 186a

Other conditions (Include pregnancy within 3 months of death) 18

Major findings:
Of operations

Of autopsy None

Duration

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) See above 123

(b) Date of occurrence 10-7-42

(c) Where did injury occur? at home-fell down stairs (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)

While at work No (e) Means of injury 0

23. Signature Dorothy R. Thorne (M. D. or other)

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

(Licensed Embalmer's Statement on Reverse Side)

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. 2999

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.