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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Primary Registration District No. 1002

Registration District No. 149

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: St. Joseph Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether years, months or days) 2 months

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. 1825 Elmwood  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Elisabeth Meek

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased: Sept 22nd, 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 9 10 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Unknown

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Beulah Browder

(b) Address 1825 Elmwood St.

17. (a) Burial (b) Date thereof 7/5/43  
(Date of interment, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stotesburg Mo.

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 East 15th, St.

19. (a) 7-2-43 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2nd, year 1943 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from June 14, 1943, to June 30, 1943.  
that I last saw her alive on June 30, 1943.  
and that death occurred on the date and hour stated above.

Immediate cause of death: Primary anemia (origin unknown)

Due to 7/3/43

Other conditions: None  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: As above

Of autopsy As above

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) (e) Means of injury

23. Signature D. A. Williams, M.D. (M. D. or other)  
Address By brain surgeon, M.D. Date signed 7-2-43

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 *John B. Camp*  
Licensed Embalmer No. *291355*  
P. O. Address *J. C. 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.