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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1367
5590

FILED JAN 19 1944

Registration District No. 1449

Primary Registration District No. 1002

Registrar's No.

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: 417 West 14 St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 13 yrs

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.: 417 West 17 St.
(If rural, give location)

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

3. (a) PRINT FULL NAME: Elizabeth Driscoll

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Femal

5. Color or race: White

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

6. (b) Name of husband or wife: Charles Driscoll

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

7. Birth date of deceased: Jan. (Month) 1 (Day) 1857 (Year)

8. AGE:

Years	Months	Days	If less than one day
86	11	15	____ hr. ____ min.

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

10. Usual occupation: At Home

11. Industry or business: ____

FATHER
12. Name: James Nichols
13. Birthplace: No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Martha Ward
15. Birthplace: No Record (City, town, or county) (State or foreign country)

16. (a) Informant: Samuel Mitchell
(b) Address: 413 West 13 St

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Dec 29 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Leavenworth Kas.

18. (a) Signature of funeral director: Mrs. C. L. Forster
(b) Address: 918 Brooklyn

19. (a) Dec 29 1943 (Date received by registrar) (b) T E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 27
year: 1943 hour: 6 minute: 30 P.M.

21. I hereby certify that I attended the deceased from Deputy Coroner, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease

Due to: ____

Due to: ____

Other conditions: 93%
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations: ____
Of autopsy: Inspection & History

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury: ____

23. Signature: Geo. E. Gaither (M. D. or other)
Address: 23 McCoy Date signed: 12-29-43

(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 Thomas C. Redmon

Licensed Embalmer No. 2737

P. O. Address W. 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.