No. 2
—2-43
-17-39
X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 5 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13678

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1727

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 4436 Broadway 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 39 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 4436 Broadway
(If rural, give location)
(e) Citizen of foreign country? U.S. Citizen (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME Martha-Frances-Borland Glines

3. (b) If veteran, name war ✓

3. (c) Social Security No. 495-05-4427

4. Sex F.E.

5. Color or race White

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

6. (b) Name of husband or wife Single

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

7. Birth date of deceased Oct- 23- 1904
(Month) (Day) (Year)

8. AGE: Years 39 Months 5 Days 28 25 If less than one day ✓ hr. ✓ min.

9. Birthplace Higginsville Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Harry Borland
13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary L. Nipper
15. Birthplace Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary L. Borland
(b) Address 4436 Broadway

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Apr. 20-44 (Month) (Day) (Year)
(c) Place: burial or cremation Higginsville MO

18. (a) Signature of funeral director J. P. Doehler
(b) Address 1415 East 15

19. (a) 4-19-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 18
year 1944 hour 6 minute 3 A M.

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

Immediate cause of death Aspiration Pneumonia

Due to Ingestion of poison type unknown, pending

Due to Chemical investigation

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy See above

163-15

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) Suicide
(b) Date of occurrence April 17, 1944
(c) Where did injury occur? Kansas City Mo
(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? NO (e) Means of injury Poison

23. Signature A. E. Upsher (M. D. or other) M.D.
Address 23rd & McCay Date signed 4/18/44

(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 H P Doehler

Licensed Embalmer No. 1166

P. O. Address 1415 E 15

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.

S. No. 2B
M—2-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 1727

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4436 Broadway (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No. (If rural, give location)

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

3. (a) PRINT FULL NAME Martha Frances Glines

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

6. (a) Single, widowed, married, divorced separated not divorced

6. (b) Name of husband or wife George J. Glines

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

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-26-1944 (Date received local registrar) (b) T E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 18 year 1944 hour minute M.

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

Immediate cause of death Aspiration of Pneumonia

Due to Ingestion of Poison

Due to Barbituric acid (proven chemically

Other conditions acute alcoholism (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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)

(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 A. E. Vasher (M. D. or other)

Address R C Mo Date signed

13678