

FILED DEC 22 1944
Registration District No. _____

Primary Registration District No. **1002**

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:
1321 East 10 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 50 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ellen Stall

3. (b) If veteran, name war no

3. (c) Social Security No. no

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

6. (b) Name of husband or wife Robert Stall 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar. 20 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>8</u>	<u>13</u>	_____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Adam Holtsberg

13. Birthplace _____
(City, town, or county) (State or foreign country) Pa.

14. Maiden name Salina Taylor

15. Birthplace _____
(City, town, or county) (State or foreign country) Illinois

16. (a) Informant Mrs Lottie Trueb

(b) Address 1321 East 10 St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

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

(b) Address (218 Brooklyn

19. (a) Dec 5, 1944 (b) Jo Brown
(Date received local registrar) (Registrar's signature)

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. 1321 East 10 St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1944 hour 11 minute 30 A M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to Myocardial

Due to _____

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

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Major findings: Inspection & History

Of operations _____

Of autopsy as above

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 3

23. Signature Jo Brown (M. D. or other) _____
Address 11424 ... Date signed 12-3-44

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 *Wm K. Jackson*

Licensed Embalmer No. *3954*

P. O. Address *KC 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.