

FILED FEB 6 1945  
Registration District No. 149

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:  
4011 BELL STREET  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community 8 YEARS 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County JACKSON  
(c) City or town KANSAS CITY 47  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4011 BELL STREET 3  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country h

3. (a) PRINT FULL NAME MRS. ETTA MAY ELLIOTT  
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 WIDOWED  
6. (b) Name of husband or wife MR. WILLIAM H. ELLIOTT  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased SEPTEMBER-22-1893  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JAN day 14<sup>TH</sup>  
year 1945 hour 11 minute 35 A.M.  
21. I hereby certify that I attended the deceased from 12-27-45 to 1-14-45  
that I last saw her alive on 1-13-45  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
71 3 22 hr. min.

Immediate cause of death  
Diabetic Coma with gangrene  
Due to

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

Other conditions (Include pregnancy within 3 months of death)  
Due to

11. Industry or business  
12. Name GEORGE FOLLETT  
13. Birthplace ILLINOIS  
(City, town, or county) (State or foreign country)  
14. Maiden name LYDIA  
15. Birthplace ILLINOIS  
(City, town, or county) (State or foreign country)

Major findings: none  
Of operations no  
Of autopsy none  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. ROY T. BROMAN  
(b) Address 4011 BELL STREET  
17. (a) CREMATION (b) Date thereof JAN-16-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation D.W. NEWCOMER'S SONS  
18. (a) Signature of funeral director D.W. Newcomer's Sons  
(b) Address 1401 BRUSH CREEK BLVD.  
19. (a) 1-15-45 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

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 P. E. Brown (M. D. or other)  
Address 178 Poplar St. New Date signed 1/15/45

Mr. G. [redacted]  
1228 Professional Bldg.  
10-12:30-4:30-4

**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 Emile W. Calhoun  
Licensed Embalmer No. 3506  
P. O. Address R. C. Ho

**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.**