. S. No. 2
OM—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 28 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 6282

Registration District No. 15A

Primary Registration District No. 5575

Registrar's No. 9

18
0
0

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution:
7800 Main
(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 23 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Jackson

(c) City or town Kansas City Mo. - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 7800 Main Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Mollie Elking

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe

5. Color or race Wh

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept. 15th 1865 (Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 27 If less than one day ..... hr. ..... min.

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

10. Usual occupation Home

11. Industry or business

MOTHER FATHER

12. Name John Brooks

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

14. Maiden name Mary Jane Davis

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

16. (a) Informant Mrs. Leo Phillips

(b) Address 7800 Main St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-45 (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo.

18. (a) Signature of funeral director Clarkson Roe

(b) Address 7406 Wornall Rd

19. (a) 2/15/1945 (Date received local registrar) Lucie W. Lindsey Pkm (Registrar's signature)

Dr. Annie B. Hedges

(Licensed Embalmer's Statement on Reverse Side)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 12 year 1945 hour 1130 minute A. M.

21. I hereby certify that I attended the deceased from Jr March 14, 1943 to Feb. 12, 1945; that I last saw he alive on Feb. 11 - 1945, 19..... and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Hypostatic Pneumonia | 2 days |
| Due to Bronchitis | 2 yrs |
| Due to Myocarditis | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations none | |
| Of autopsy none | |

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. F. Clark M.D. (M. D. or other)

Address 908½ W. 75 Date signed 2-43 '45

## 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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**