

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
FILED OCT 29 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. **4245**

Registration District No. **149** Primary Registration District No. **1002**

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

48
3
8

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: General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 WEEKS
(Specify whether years, months or days)

In this community 50 YEARS
(years, months or days)

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. 2424 Troost
(If rural, give location)

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

3. (a) PRINT FULL NAME Ella V. Estes

3. (b) If veteran, name war No 3. (c) Social Security No. NO ONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. HENRY ESTES 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased DECEMBER 24 1883
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14
 year 1945 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from August 11 1945 to October 14 1945
 that I last saw her alive on October 14 1945
 and that death occurred on the date and hour stated above.

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| <u>81</u> | <u>9</u> | <u>20</u> | _____ hr. _____ min. |

Immediate cause of death Carcinoma of breast with metastasis to lungs

Due to _____

Due to _____

Other conditions 50
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER

12. Name HARRISON BENEFIELD

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

14. Maiden name UNKNOWN

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

16. (a) Informant MRS. LULA ALLEN

(b) Address RICH HILL, MISSOURI

17. (a) BURIAL (b) Date thereof OCT-16-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT WASHINGTON CEM.

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BROOK CREEK BLDG.

19. (a) 10-16-45 (b) Geraldine Holmes
(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 Clark W. Seely (M. D. or other) _____
 Address MED. DIR. K.C. GENERAL HOSP. Date signed OCT-15-1945

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. Oebow

Licensed Embalmer No. 3506

P. O. Address KCM

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.