

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1783**
Registrar's No. **5369**

FILED JAN 21 1946
Registration District No. **21946**

Primary Registration District No. **1002**

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

100402

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:
Home- 4816 Harrison 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 72 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary A. Steele

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 Frank W. Steele

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

7. Birth date of deceased May 18th, 1857
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>88</u>	<u>7</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name William Mulkey

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

14. Maiden name Sarah Wells

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

16. (a) Informant Mrs. Elizabeth Packer

(b) Address 4816 Harrison St.

17. (a) Burial (b) Date thereof 12/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Farr Funeral Home

(b) Address 4130 East 15th, St.

19. (a) 12-27-45 (b) A Geraldine Holmes
(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. 4816 Harrison
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 24th.
year 1945 hour 10 minute 30P. M.

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

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis

Due to _____

Other conditions 830
(Include pregnancy within 3 months of death)

Major findings: 830
Of operations _____

Of autopsy no
Heston & Inspectum

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 Geraldine Holmes (M. D. or other) Coroner
Address 4224 1/2 St. Date signed 12-26-45

Duration _____

PHYSICIAN _____

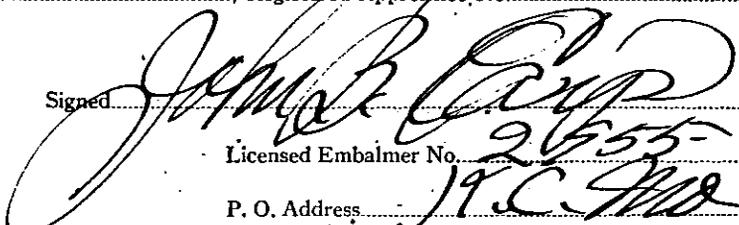
Underline the cause to which death should be charged statistically.

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. 2655-.....

P. O. Address 19 C. 9th.....

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.