

S. No. 2
M-5-43
5-17-39
I X36671

FILED JUN 20 1946
Registration District No. **746**

Primary Registration District No. **3026**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Independence, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Independence Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **18 hours**
(Specify whether years, months or days)

In this community **18 hours**

3. (a) PRINT FULL NAME **Mary Lee Easter**

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 **Infant**

6. (b) Name of husband or wife **None**

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

7. Birth date of deceased **May 4 4 1946**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

18hr. min.

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

10. Usual occupation **Infant**

11. Industry or business **Infant**

12. Name **Marion Leland Easter**

13. Birthplace **Cameron Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Ona Elaine Walker**

15. Birthplace **Springfield, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **M. L. Easter**

(b) Address **2431 Vermont**

17. (a) **Burial** (b) Date thereof **May 6, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills**

18. (a) Signature of funeral director **Lang B. Harrison**

(b) Address **101 No. Pleasant**

19. (a) **June 6, 1946** (b) **Sam Beech**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Independence, Mo.**
(If outside city or town limits, write "RURAL")

(d) Street No. **2431 Vermont**
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **4th**
year **1946** hour **6** minute **30** P. M.

21. I hereby certify that I attended the deceased from **May 4, 1946** to **May 4, 1946**
that I last saw her alive on **May 4, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Pulmonary Congestion**

Due to **Circulatory Failure**

Due to **Patent Foramen Ovale.** **18 hours**

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: **None**

Of operations **None**

Of autopsy **See above**

PHYSICIAN **None**
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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature **Harold V. Woods M.D.**
Address **Independence Mo.** Date signed **5/5/46**

