

No. 2
-5-43
-17-39
X36671

FILED JUN 20 1946

Registration District No. **76** Primary Registration District No. **5568**

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

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution:
1435 Ralston / (Blue Jay)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community **75 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

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

(d) Street No. **1435 Ralston**
(If rural, give location)

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

3. (a) PRINT FULL NAME **ELIZABETH MARY EWING**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female /** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married /**

6. (b) Name of husband or wife **William W. Ewing**

6. (c) Age of husband or wife if alive **76** years

7. Birth date of deceased **Feb. 19 1871**
(Month) (Day) (Year)

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

75	3	11	hr. min.
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9. Birthplace **Jackson Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

MOTHER FATHER

11. Industry or business _____

12. Name **John W. Tyer**

13. Birthplace **Unknown Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name **Amanda George**

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

16. (a) Informant **William W. Ewing**

(b) Address **1435 Ralston, Independence, Mo.**

17. (a) **Burial** (b) Date thereof **6/1/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oakland Cem. - on**

18. (a) Signature of funeral director **Geo. C. Carson**

(b) Address **Independence Missouri**

19. (a) **June 6-1946** (b) **Geo. C. Carson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **30** th.
year **1946** hour **10** minute **45** P. M.

21. I hereby certify that I attended the deceased from **May 9, 1946**
May 30, 1946 to **May 30, 1946**
that I last saw her alive on **May 30, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial insufficiency & lost compensation** Duration **5 mos.**

Due to _____

Due to **Chron. interstitial nephritis** **15 years & mos**

Other conditions **cardiac asthma**

4 (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: **12/15**

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)

(g) Means of injury _____

23. Signature **J. N. Hall M.D.** (M. D. or other) **6-1-46**
Address **1438 Hedgas Ave Indef. Mo** Date signed

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.....

Raymond N. Martin

Licensed Embalmer No..... *4130*

P. O. Address..... *Indep Mo*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 2007

Registration District No. 176

Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Elizabeth M. Ewing

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb 19 (Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ (Less than one day) hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) James Craig (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

20680