

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

FILED JUL 31 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2995

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: St. Joseph Hospital
(d) Length of stay: 1 day
In this community Most of Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 812 West 29th St.
(e) Citizen of foreign country? No

3. (a) PRINT WILLIAM H. ELLEDGE
FULL NAME

3. (b) If veteran, No name war
3. (c) Social Security No. None

4. Sex Male 5. Color or race Wh
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Katherine Elledge
6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased September 23 1874
(Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days 15
If less than one day hr. min.

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

10. Usual occupation House Wrecking

11. Industry or business Contractor

12. Name No Record

13. Birthplace " "

14. Maiden name Elizabeth Jackson
(City, town, or county) (State or foreign country)

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Katherine Elledge
(b) Address 812 West 29th Street

17. (a) Burial (b) Date thereof 7-12-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill
(d) Signature of funeral director J. W. Wagner
(e) Address Kansas City, Mo.

19. (a) 7-9-46 (b) Geraldine Holme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1946 hour nine minutes 45 a.m.
21. I hereby certify that I attended the deceased from July 8 to July 8
that I last saw him alive on July 8 and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Myocardial Failure
Due to: Coronary Occlusion
Duration: 2 hrs

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

Major findings: Of operations: 94a
Of autopsy: _____

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? _____
(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 _____
Signature: J. P. Hoffman (M. D. or other)
Address: _____ Date signed: _____

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

MOTHER FATHER

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 Alvin R. Hainschiff

..... Licensed Embalmer No. 4159

..... P. O. Address K.C. 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.