

STANDARD CERTIFICATE OF DEATH

State File No. _____

4165

Registration District No. _____

149

Primary Registration District No. 1002

Registrar's No. _____

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:
1815 East 7th Street
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 18 yrs.
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. 1815 East 7th Street
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Viola Grace Neil
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 9 day 30
 year 1946 hour 11 45 minute a M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Divorced
 6. (b) Name of husband or wife Gilbert B. Neil
 6. (c) Age of husband or wife if alive 24 years
 7. Birth date of deceased July 28 1924
(Month) (Day) (Year)

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

8. AGE: Years Months Days If less than one day
22 2 2
 hr. _____ min.

Immediate cause of death Pneumonia
 Duration _____

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

Due to _____
 Due to _____

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) 107

11. Industry or business _____
 12. Name Samuel F. Long
 13. Birthplace Minn.
(City, town, or county) (State or foreign country)
 14. Maiden name Grace Bean
 15. Birthplace Iowa
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
 Of autopsy yes as above
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Grace Long
 (b) Address 1815 East 7th Street
 17. (a) Burial (b) Date thereof 10/3/46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Washington

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 _____

18. (a) Signature of funeral director Earp & Sons
 (b) Address 4139 East 15th Street
 19. (a) 10-2-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) _____
 Address 1424 [Address] Date signed 8-30-46

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

200

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.....

John B. Camp
.....

Licensed Embalmer No. *2955*.....

P. O. Address *H.C. 9mo*.....

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.