

U. S. No. 2
FORM-5-43
Rev. 5-17-39
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13445

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1819

FILED MAY 5 1947
Registration District No. 17

Primary Registration District No. 1002

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

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 35 years
years, months or days)

3. (a) PRINT FULL NAME Mrs Nellie Friend
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 Married
6. (b) Name of husband or wife Robert Allen Friend
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased July 21 1892
(Month) (Day) (Year)

8. AGE: Years 54 Months 8 Days 28
If less than one day hr. min.

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

10. Usual occupation Busker

11. Industry or business _____

12. Name Gorman

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

14. Maiden name No Record

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

16. (a) Informant Robert A Friend

(b) Address 5827 Bellefontaine

17. (a) Burial (b) Date thereof 4/22/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Wm J Hart
(b) Address 20 West Linwood

19. (a) 4-22-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
Missouri
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5827 Bellefontaine
(If rural, give location)
(e) Citizen of foreign country? unknown or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 19
year 1947 hour 4 minute _____ A. M.

21. I hereby certify that I attended the deceased from
April 12 1947 to April 19 1947
that I last saw h. alive on April 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of right breast with metastasis to liver
Lobar pneumonia

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

Major findings: 50
Of operations _____
Of autopsy See above

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 0
23. Signature Wm J Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 4-19-47

