

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 27 1948

Registration District No. 789

Primary Registration District No. 1002

Registrar's No. 213

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 10 days
(Specify whether
 In this community 50 years
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. 812 Benton
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Susan Boyd
 3. (b) If veteran, name war no
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 12
 year 1948 hour 9 minute 10 P.M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 19 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 2, 1948, to Jan. 12, 1948;
 that I last saw her alive on Jan. 12, 1948;
 and that death occurred on the date and hour stated above.

8. AGE: Years 89 Months 9 Days 23
 If less than one day _____ hr. _____ min.

Immediate cause of death
Generalized arteriosclerosis
Arteriosclerotic heart disease
Possible carcinoma of ovary
 Due to Hydrothorax left

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

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

10. Usual occupation Housewife

11. Industry or business _____

Major findings:
 Of operations _____
None
 Of autopsy _____

12. Name Dolan
 13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Don't know
 15. Birthplace "
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Shea (Conv. Home)
 (b) Address 812 Benton

17. (a) Burial (b) Date thereof 1/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Wt. Washington Cem.

18. (a) Signature of funeral director Carroll Davidson
 (b) Address 3024 Troost, S.C. Mo.

19. (a) 1-16-48 (b) Gertrude Holmes
(Date received local certificate) (Registrar's signature)

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 Wm W. Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 1-13-48

Dr. Johnson

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 *Kathryn E. Davidson*

Licensed Embalmer No. *3648*

P. O. Address.....

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.