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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED FEB 17 1948

U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4795**
Registrar's No. **527**

Registration District No. **149**

Primary Registration District No. **1002**

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:
3940 MCGEE 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **60 YEARS** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3940 McGee**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **SADIE ELLEN DENZEL**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**
4. Sex **FE** / 5. Color or race **W**
6. (a) Single, widowed, married, divorced **WID.**
6. (b) Name of husband or wife **THOMAS DENZEL**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **OCTOBER 29 1862**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **4**
year **1948** hour **4** minute **13** M.
21. I hereby certify that I attended the deceased from **Feb 17**
1948 to **Feb 4** 1948
that I last saw her alive on **Jan 31** 1948
and that death occurred on the date and hour stated above.

8. AGE: Years **85** Months **3** Days **5**
If less than one day hr. _____ min. _____

Immediate cause of death **Chronic Coronary fibrillation**
Due to **Chronic Myocarditis**
Due to _____
Other conditions **Senility**
(Include pregnancy within 3 months of death)

9. Birthplace **JACKSBORO TEXAS**
(City, town, or county) (State or foreign country)
10. Usual occupation **HOUSEWIFE**

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

MOTHER FATHER
11. Industry or business _____
12. Name **P. S. SHELLY**
13. Birthplace **Ky.**
(City, town, or county) (State or foreign country)
14. Maiden name **SARAH MILLER**
15. Birthplace **Ky.**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **Naomi L. Owings**
(b) Address **4403 Iowa**
17. (a) **Burial** (b) Date thereof **Feb. 7, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Washington**
18. (a) Signature of funeral director **Mr. C. L. Jantz**
(b) Address **916 Broadway**
19. (a) **2-6-48** (b) **Herbeline Holmes**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature **A. J. Shaffard** (M. D. or other)
Address **1212 1/2 E. 12th St. Mo.** Date signed **2-6-48**

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

1 - pm
VT 4425
Average Body

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 Joe B. Yoder
Licensed Embalmer No. 4173
P. O. Address 918 Brooklyn

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.

K.C. No.