

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 Childrens Mercy Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Hrs 10 min  
(Specify whether years, months or days) 2 Hrs 10 min

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry  
(c) City or town Urich R# 1.5  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

DOIS ANN Nold

(b) If veteran, name war no

(c) Social Security No. none

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

7. Birth date of deceased May 1 1948  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
5 2 1 hr. 1 min.

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

10. Usual occupation infant

11. Industry or business \_\_\_\_\_

12. Name James F Nold

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

14. Maiden name Irene Gath

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

16. (a) Informant James Nold  
(b) Address Mont Urich Mo

17. (a) Burial (b) Date thereof 5-4-48  
(Place, cremation, or removal) (Month) (Day) (Year)  
Clinton Mo German town Cem  
(c) Place: burial or cremation

18. (a) Signature of funeral director Sickman - Dunning  
(b) Address Clinton Mo

19. (a) 5-4-48 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3rd  
year 1948 hour 4 minute 10 P M.  
21. I hereby certify that I attended the deceased from May 3rd  
Pathological 19 48 to May 3 19 48  
that I last saw her alive on May 3 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Atelectasis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 1000

Major findings:  
Of operations \_\_\_\_\_  
Pneumonia  
Of autopsy: Atelectasis  
St. Cerebral Hemorrhage

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? \_\_\_\_\_ (Specify type of place)  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address St. Luke's Hoop Date signed 5-3-48

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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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.....  
*not embalmed*..... Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.