

No. 2  
M-5-43  
5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16321  
Registrar's No. 2002

FILED MAY 22 1948

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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 hrs. 25 mins.  
In this community 39 yrs.  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Elizabeth Folliett  
3. (b) If veteran, name war no  
3. (c) Social Security No. no

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Frank Folliett 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Oct 5 1881  
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 3  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER  
12. Name Bee  
13. Birthplace No Record 9  
(City, town, or county) (State or foreign country)  
14. Maiden name No Record  
15. Birthplace No Record 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. C. Foster  
(b) Address 3515 - E - 18 St  
17. (a) Burial (b) Date thereof May 11 - 48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mr. C. Foster  
(b) Address 918 Brooklyn

19. (a) 5-11-48 (b) S. Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3446 E. 19 St. 6  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 8  
year 1948 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from May  
8, 1948 to 5-8, 1948  
that I last saw her alive on 5-8, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cholecystitis and cholelithiasis (Stones)  
Duration

Due to  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 126  
Of autopsy See above  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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  
23. Signature Wm. W. Hart (M. D. or other) no  
Address Med. Dir. Gen'l Hosp. Date signed 5-10-48

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

*Dr. Powell*

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address. *918 Brookline  
Ct., Me.*

**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.**