

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26378**

FILED AUG 29 1949

BIRTH NO. _____		REG. DIST. NO. <u>69</u>		PRIMARY REG. DIST. NO. <u>4097</u>		Registrar's No. <u>130</u>	
1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Cass</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Harrisonville</u>		c. LENGTH OF STAY (If this place) <u>27 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Harrisonville</u>		d. STREET ADDRESS (If rural, give location) <u>Sycamore St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>At home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED a. (First) <u>Eleanor</u> (Type or Print)		b. (Middle) <u>Amanda</u>		c. (Last) <u>Cain</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 20 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb 7-1884</u>	
9. AGE (In years last birthday) <u>65</u>		10. MONTHS <u>6</u>		11. DAYS <u>13</u>		12. HOURS <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Marshalltown Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Kennedy</u>		13b. MOTHER'S MAIDEN NAME <u>Hattie Straw</u>		14. NAME OF HUSBAND OR WIFE <u>Jessie G. Cain</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Jessie Cain Harrisonville MO</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Tuberculosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>102X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Mar</u> , 1947, to <u>Aug</u> , 1949, that I last saw the deceased alive on <u>Aug 20 1949</u> , and that death occurred at <u>8:15 P.M.</u> , from the cause and on the date stated above.							
23a. SIGNATURE <u>S. Jones, M.D.</u>				23b. ADDRESS <u>Harrisonville MO</u>		23c. DATE SIGNED <u>8-23-49</u>	
24a. BURIAL CREATION, REMOVAL (Specify)		24b. DATE <u>Aug 23-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Harrisonville MO</u>	
DATE REC'D BY LOCAL REG. <u>Aug 23, 1949</u>		REGISTRAR'S SIGNATURE <u>Saura J. Jones</u>		51		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Harrisonville MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Woyd Atkinson

Licensed Embalmer No. 3920

P. O. Address Harrisonville

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.