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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 9 1947

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24515

Registration District No. 154
Primary Registration District No. 5575
Registrar's No. 26

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Grandview,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
entire life
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo.
(b) County Jackson 48
(c) City or town Grandview
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MARTHA ELLEN TRUMAN
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John A. Truman
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 25 1852 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
94	8	1	hr. min.

9. Birthplace Jackson Co., Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Solomon Young
13. Birthplace Shelby Co., Ky.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Harriet L. Gregg
15. Birthplace Shelby Co., Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Harry S. Truman
(b) Address Washington, D. C.
17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof 7/28/47 (Month) (Day) (Year)
(c) Place: burial or cremation Forrest Hill Cemetery-K. C., Mo.
18. (a) Signature of funeral director E. R. George & Sons
(b) Address Grandview, Mo.
19. (a) July 29-'47 (Date received local registrar)
(b) Dr. Annie G. Hedges (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26 year 1947 hour 11:05 minute a. M.

21. I hereby certify that I attended the deceased from Feb 13 1947 to July 26 1947
that I last saw her alive on July 26 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Due to
Due to
Other conditions Fractured right femur 2/13/47
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

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 J. W. Greene (M. D. or other)
Address Independence, Mo
Date signed 7/26/47

(Licensed Embalmer's Statement on Reverse Side)

FEB 25 1949

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 A. K. George

Licensed Embalmer No. 3645

P. O. Address Grandview Mi

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, above space should be left blank.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. ______

Registration District No. 154 Primary Registration District No. 5571 Registrar's No. 26

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Grandview
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ______ In this community ______ (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Martha E. Truman
3. (b) If veteran, name war ______ 3. (c) Social Security No. ______
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife ______ 6. (c) Age of husband or wife if alive ______ years
7. Birth date of deceased Nov- 25 (Month) (Day) (Year)
8. AGE: Years 94 Months ______ Days ______ If less than one day ______ hr. ______ min.
9. Birthplace ______ (City, town, or county) Mo (State or foreign country)
10. Usual occupation ______
11. Industry or business ______
FATHER
12. Name ______
13. Birthplace ______ (City, town, or county) ______ (State or foreign country)
MOTHER
14. Maiden name ______
15. Birthplace ______ (City, town, or county) ______ (State or foreign country)
16. (a) Informant ______
(b) Address ______
17. (a) ______ (Burial, cremation, or removal) (b) Date thereof ______ (Month) (Day) (Year)
(c) Place: burial or cremation ______
18. (a) Signature of funeral director ______
(b) Address ______
19. (a) ______ (Date received local registrar) (b) ______ (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 26 year 1947 hour ______ minute ______ M.
21. I hereby certify that I attended the deceased from ______, 19__, to ______, 19__; that I last saw h__ alive on ______, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death The fracture was	
Due to entirely united	
Due to Death was due to the fracture directly	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations ______	
Of autopsy ______	

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 2/13/1947
(c) Where did injury occur? Grandview Jackson Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home in bedroom (Specify type of place)
While at work? ______ (e) Means of injury fall
23. Signature J. W. Greene (M. D. or other)
Address Independence Mo Date signed ______

FEB 25 1943