

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4216

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Research Hospital, K.C. Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary M. Nance 520
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 name war _____ No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Joel L. Nance 6. (c) Age of husband or wife if alive _____ years
 Joel L. Nance alive _____ years
7. Birth date of deceased Feb. 8th, 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>8</u>	<u>24</u>	hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Henry Looney 9

13. Birthplace No Record ?
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Maher ?
(City, town, or county) (State or foreign country)

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature The Winkler Funeral Home

(b) Address Lexington, Mo.

17. (a) Burial (b) Date thereof By Auto Nov. 3-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn Avenue, K.C. Mo.

19. (a) 11/3/39 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Res: Lexington, Missouri
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2nd
year 1939 hour 10 minute 12 P. M.

21. I hereby certify that I attended the deceased from November 2nd, 1939, to November 2nd, 1939; that I last saw her alive on November 2nd, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 2 days

Due to Chronic myelogenous leukemia 4 yrs

Due to T.D.A.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Leukemic infiltration of bone marrow, liver and spleen

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)
(e) Means of injury _____

23. Signature C. J. Kent (M. D. or other) MD

Address 2300 Holmes, K.C. Mo. Date signed 11/3/39

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 16 1947

APR 9 1947

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 C. H. Wise

Licensed Embalmer No. ~~2570~~ 2570

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, above space should be left blank.