

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.

Registration District No. **1939 399**

Primary Registration District No. **1002**

Registrar's No. **4386**

1. PLACE OF DEATH:

(a) County Jackson **2**

(b) City or town Kansas City, Missouri

(c) Name of hospital or institution:
629 West 38th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution About 50 Yrs. (Specify whether years, months or days)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED: **1**

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 629 West 38th Street
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mrs. Anna M. Churchman **625**

(b) If veteran, name war no

3. (c) Social Security No. NOVE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15 year 1939 hour 12:30 minute PM M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alfred Churchman

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased March 22 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1935 and Dr. H.H. Hove that I last saw h. or alive on Aug 1937, 1939; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>7</u>	<u>23</u>	hr. _____ min.

Immediate cause of death: Cerebral hemorrhage **10-15 min.**

9. Birthplace Buffalo, New York
(City, town, or county) (State or foreign country)

Due to Arteriosclerosis, generalized ?

Due to 82 yr

10. Usual occupation Housewife

Other conditions (include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy None

11. Industry or business _____

MOTHER FATHER

12. Name Moses T. Mabie

13. Birthplace New York
(City, town, or county) (State or foreign country)

14. Maiden name Mary Mabie

15. Birthplace New York
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Alfred Churchman

(b) Address 629 West 38th Street

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? _____

17. (a) Burial (b) Date thereof Nov. 17 '39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

23. Signature Lynman K. Richardson (M. D. or other) **1**

Address 906 Grand Date signed 11/16/39

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3811 Broadway

19. (a) Nov 17 1939 (b) M. M. Cronin
(Date received local registrar) (Registrar's signature)

NOV. 21-1939
FORM 1 X1931

S.W. Cor. 9th & Grand

Dr. J. K. Richardson
1004 Grand

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 _____

Ralph E. Miller

Registered Apprentice No. *164*

working under my personal supervision.

Signed _____

Joseph Keeler

Licensed Embalmer No. *3738*

P. O. Address *3811 Bolway, N.C.M.*

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.