

**DEC 11 1939**  
Registration District No. **399**

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:  
Plaza Hotel, 13 East 24th  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
Unknown (Specify whether  
In this community  
years, months or days) 651

3. (a) PRINT FULL NAME MRS. CHARLOTTE TROMBLEE  
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 F. E. Tromblee  
6. (c) Age of husband or wife if alive — years  
7. Birth date of deceased No Record  
(Month) (Day) (Year)

8. AGE: Years 65 ? Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation None

11. Industry or business 9

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

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

16. (a) Informant's own signature Robert Tromblee  
(b) Address Albany NY

17. (a) Burial (b) Date thereof 11-22-39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Maple Hill

18. (a) Signature of funeral director Quirk & Johnson Co.  
(b) Address A.C. from

19. (a) 10/22/1939 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 2  
(a) State New York (b) County Don't Know  
(c) City or town Plattsburgh  
(If outside city or town limits, write "RURAL")  
(d) Street No. No Record  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 30  
year 1939 hour 8:30 minute 17 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
Arrived  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cyanide Poisoning  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy yes

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) suicide  
(b) Date of occurrence 10/30/39  
(c) Where did injury occur? 13 East 24th Kaw  
(City or town) (County) (State)  
(d) Did injury occur in or about home, or farm, in industrial place, in public place?  
Home  
(Specify type of place)  
While at work \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 4  
Address [Signature] Date signed 11/2/39

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.

1 X 1951

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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 *Maurice Maurick*.....

Licensed Embalmer No. *2224*.....

P. O. Address *K. C., Mo.*.....

**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.**