

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. **399**

Primary Registration District No. **1002**

Registrar's No. **4652**

JAN 15 1940

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-7-to 12-2-39
(Specify whether 15 years years, months or days)

8. (a) PRINT FULL NAME

Eunice Owens

8. (b) If veteran, name war No

3. (c) Social Security No. 492-14-8306

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Rasco Owens

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

7. Birth date of deceased 6 (Month)

27 (Day)

1907 (Year)

8. AGE:

Years 32

Months 5

Days 5

If less than one day

hr. min.

9. Birthplace

La.
(City, town, or county)

La.
(State or foreign country)

10. Usual occupation

Cook

11. Industry or business

12. Name Unknown Joseph L Johnson

13. Birthplace Unknown La
(City, town, or county) (State or foreign country)

14. Maiden name Jane Wallace

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

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital No. 2

17. (a) Removal (b) Date thereof 12/7-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shreveport La

18. (a) Signature of funeral director Stallins Bros.

(b) Address 1729 Lyden

19. (a) Dec. 17, 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1219 E. 18th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 2
year 39 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from 11-7, 1939 to 12-2, 1939
that I last saw her alive on 12-2, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Peritonitis

Due to Intestinal Obstruction
due to Post Operative Adhesions.

Due to 12-2-39
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Uterine Fibroid
(non malignant)
Of autopsy Above mentioned.

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 J. Atkinson (M. D. or other)
Address General Hospital #2 Date signed 12-5

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Isaac Jerome Mendenhall

Licensed Embalmer No.

3994

P. O. Address

1120 E. 23rd St

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.