

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)
In this community 45 Years.

3. (a) PRINT FULL NAME Hattie Harrison 625

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Jno. M. Harrison 6. (c) Age of husband or wife if alive Died 1917 years

7. Birth date of deceased March 29th, 1864
(Month) (Day) (Year)

8. AGE: Years 75- Months 8 Days 15 If less than one day hr. min. 0

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

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant's own signature George Harrison by wife

(b) Address 1310 West 20th, St. Terr. K.C. Mo.

17. (a) Burial (b) Date thereof Dec. 18th, 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ship to Slater, Mo.

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

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

19. (a) Dec. 16, 1939 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1012 Harrison
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14th
year 1939 hour 8 minute 12 P. M.

21. I hereby certify that I attended the deceased from Dec. 4th
1939, to Dec. 14th, 1939;
that I last saw her alive on December 14th, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured right ventricle of heart

Due to arteriosclerotic heart disease

Due to 958²⁰

Other conditions Passive congestion of lungs
(Include pregnancy within 3 months of death)

Major findings: Of operations.

Of autopsy See above.

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 W. H. De Maria, M.D. (Physician or other)

Address Supt. K.C. Gen. Hospital 12-15-39 Date signed _____

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.

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Theron A. Redman

Licensed Embalmer No. 2737

P. O. Address H. C. Me

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.