

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. 4836

JAN 13 1940

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City, Mo.
 (c) Name of hospital or institution:
121 S Lawndale
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 79 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Lucy B. Simpson 512-
 8. (b) If veteran, name war --None
 8. (c) Social Security No. None

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

6. (b) Name of husband or wife James
 6. (c) Age of husband or wife If alive _____ years

7. Birth date of deceased Oct. 10, 1860
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 2 12 hr. min.

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

10. Usual occupation Homemaker

11. Industry or business _____

MOTHER FATHER { 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 Mrs. Pearl Walkley

(b) Address 1907 Linwood

17. (a) Burial (b) Date thereof Dec. 23-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hill, Mo.

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address K. C. Mo.

19. (a) Dec. 22, 1939 (b) M. M. Browne
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Jackson
 (c) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 121 S. Lawndale
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 22
 year 1939 hour 5:10 AM minute _____ M.

21. I hereby certify that I attended the deceased from 12-15-39
to 12-22, 1939, to _____, 19____;
 that I last saw h. LV alive on 12-22, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death
Auricular fibrillation & Cardiac De-compensation.

Due to Mitral Insufficiency & Arterial Hypertension.

Other conditions (Include pregnancy within 5 months of death) None

Major findings: Of operations _____
 Of autopsy _____

Duration

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. A. Wilkinson (M. D. or other)

Address 1123 Grand Ave Date signed 12/22/39

Dr. E.A. Wilkinson

Prof. Bldg.

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 W.D. Blackman

Licensed Embalmer No. 3637

P. O. Address 17 C No

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.