

FEB 26 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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 8 days
(Specify whether
 In this community About 40 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
Kansas City
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 2817 Tracy
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6th
 year 1940 hour 6 minute 07A.M.

21. I hereby certify that I attended the deceased from
Nov. 30th, 1939, to Jan. 6th, 1940, 19 ;
 that I last saw her alive on Jan. 6th, 1940, 19 ;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral hemorrhage and
Chronic myodarditis.

Duration

Due to 930
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy None

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 A. J. DeMama M.D. (M. D. or other)
Supt. Gen. Hospital, K. C. Mo. Date signed _____

3. (a) PRINT FULL NAME JESSIE WEEKS 200

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife Lee C. Weeks, Deceased 6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased Sept. 30th, 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Wood

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

14. Maiden name Susan Ann Thornton

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

16. (a) Informant's own signature Carl E. Weeks.

(b) Address 2817 Tracy Avenue, K. C. Mo.

17. (a) Burial (b) Date thereof Jan. 8th, 40
(Burial, cremation, or removal) (Month) (Day) (Year)
ht. Washington Cemetery.

(c) Place: burial or cremation Mrs. C.L. Forster

18. (a) Signature of funeral director 918 Brooklyn Avenue, K.C. Mo.

(b) Address _____

19. (a) Jan. 8, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address H. 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.