

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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:  
2110 Jefferson St. 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 65 yrs.  
years, months or days)

**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. 2110 Jefferson St.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? -- years.

**3. (a) PRINT FULL NAME:** Mrs. Lulu Mathews  
**3. (b) If veteran,** -- **3. (c) Social Security**  
 name war. -- No. --  
**4. Sex:** Female **5. Color or** White  
 race White **6. (a) Single, widowed, married,**  
 divorced Widow  
**6. (b) Name of husband or wife:** Roy C. Mathews **6. (c) Age of husband or wife if**  
 alive. -- years  
**7. Birth date of deceased:** May 17, 1864  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Feb day 28  
 year 1940 hour about 9:30 P. minute M.  
**21. I hereby certify that I attended the deceased from:** 1938  
1938 to Feb 28 1940  
 that I last saw her alive on Feb 28 1940  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>9</u>	<u>12</u>	hr. _____ min.

Immediate cause of death: Chronic + acute Bronchial Asthma  
 Duration 10 yrs or more  
 Due to Food allergy - probably  
 Due to 112

**9. Birthplace:** Kansas City Mo.  
(City, town, or county) (State or foreign country)  
**10. Usual occupation:** Housewife  
**11. Industry or business:** --  
**12. Name:** ?  
**13. Birthplace:** ?  
(City, town, or county) (State or foreign country)  
**14. Maiden name:** ?  
**15. Birthplace:** ?  
(City, town, or county) (State or foreign country)

Other conditions: Cardiac Failure  
(Include pregnancy within 3 months of death)  
 Major findings: Bronchial Asthma  
 Of operations: \_\_\_\_\_  
 Of autopsy: none

**16. (a) Informant:** V. R. Hudson  
**(b) Address:** 2428 College  
**17. (a) Burial** **(b) Date thereof:** 3 - 1 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place:** burial or cremation Mt. Hope - K.C.K.  
WALTER WERNER  
**18. (a) Signature of funeral director:** WALTER WERNER  
**(b) Address:** 18th & Washington, K.C. Kans.  
**19. (a) 2-29-40** **(b) M. M. Crowe**  
(Date received local registrar) (Registrar's signature)

**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) no  
 (b) Date of occurrence none  
 (c) Where did injury occur? none  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
3 11 none  
(Specify type of place)  
 While at work? none (e) Means of injury none  
**23. Signature:** J. J. Jewett (M. D. or other) M.D.  
 Address: 1318 Bryant Bldg Date signed 2-29-40

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**