

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1009**

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:
122 Clinton Place
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 122 Clinton Place
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. years.

3. (a) PRINT FULL NAME Mrs. Elizabeth Pope

3. (b) If veteran, name war None 3. (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 Chas. H. Pope 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov. 25th, 1867
 (Month) (Day) (Year)

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

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

10. Usual occupation Homemaker

11. Industry or business ---

12. Name William Anderson

18. Birthplace Tenn
 (City, town, or county) (State or foreign country)

14. Maiden name Lary Pinnen

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

16. (a) Informant's own signature Mrs. Cora B. Day

(b) Address 122 Clinton Place

17. (a) Burial (b) Date thereof Mar. 5-10
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adonis Cemetery

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

(b) Address 2625 Indre. Blvd. K.C., Mo.

19. (a) 3-4-40 (b) M. M. Carow
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3
 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;

that I last saw him alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Bright Fibro-calcium Tuberculosis & Cavitation

Due to

Due to

Other conditions Chs. Vasculis Metabolics
 (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Same

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?

(Specify time of injury) While at work (Specify time of injury)

23. Signature (M. D. or other)

Address Date signed

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

Rev. 5-17-39

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.....

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

Signed.....

Licensed Embalmer No. 3639

P. O. Address R. 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.