

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

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.

APR 12 1940
399

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1072

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: R. A. Clark Institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
(Specify whether
In this community Unknown
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. 2843 Troost
(If rural, give location)
(e) If foreign born, how long in U. S. A. no years.

3. (a) PRINT FULL NAME Miss Nellie Frazer 626

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

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

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased October 1, 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>5</u>	<u>7</u>	hr. _____ min.

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

10. Usual occupation at home

11. Industry or business X

12. Name Winthrop Frazer

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

14. Maiden name Margaret Sargent

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

16. (a) Informant's own signature A. E. Harley

(b) Address 3339 Wabash, K. C., Mo.

17. (a) Burial (b) Date thereof 2-9-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) March 8, 1940 M. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th
year 1940 hour 10:30 minute A. M.

21. I hereby certify that I attended the deceased from Oct 1
1939 to Mar. 8, 1940
that I last saw her alive on Mar 8, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic glomerulo-nephritis
Duration 6 months

Due to 59

Other conditions Diabetes mellitus 6 years
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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? _____

(Specify type of place)
While at work? _____ Means of injury _____

23. Signature John S. Caldwell (M. D. or other) MD
Address Kansas City, Mo. Date signed 3/8/40

John K. Caldwell,
Ha 7170

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

J. K. Caldwell
.....
Licensed Embalmer No. 1415
P. O. Address 1710 E. 170

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.