

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.

FILED APR 12 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1116

1. PLACE OF DEATH:

(a) County JACKSON
 (b) City or town K. C. MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 5501 PARK ; 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 years (Specify whether years, months or days) 4-5

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County JACKSON
 (c) City or town KANSAS-CITY
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5501 PARK (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME LOUISE-DEZELL-PALMER

3. (b) If veteran, name war NONE 3. (c) Social Security No. 1

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

6. (b) Name of husband or wife GED-W 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased JULY 19 1893
 (Month) (Day) (Year)

8. AGE: Years 46 Months 7 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business L

12. Name MO. WEBB

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

14. Maiden name JESSIE ALGER

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

16. (a) Informant's own signature L. W. Palmer

(b) Address 5501 PARK AVE.

17. (a) CREMATION (b) Date thereof 3-11-40
 (Method of disposition, or removal) (Month) (Day) (Year)

(c) Placer burial or cremation Woods

18. (a) Signature of funeral director Funeral Home

(b) Address 6900 TREEST

19. (a) Mch 11, 1940 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 9 year 1940 hour 12 minutes 30 A. M.

21. I hereby certify that I attended the deceased from 1-2-40 to 3-7-40 that I last saw him alive on 3-5-40 and that death occurred on the date and hour stated above.

Immediate cause of death Secondary pneumonia
of Medical origin Duration 3 wks

Due to Identical pneumonia
of uterine wall Duration 4 wks

Other conditions (Include pregnancy within 3 months of death) 48

Major findings: Of operations Identical pneumonia
of uterine wall Of autopsy NO

Duration

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 [Signature] (M. D. or _____)
 Address 725 [Address] Date signed 3-11-40

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

Edward J. Roe

Licensed Embalmer No.

2748

P. O. Address

2117 E. 39th St.

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.