

ADD 23 1940 / 11 4

Registration District No. _____

Primary Registration District No. **1-10-11**

Registrar's No. **27**

48
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Rural - Washington Mills**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Kansas City Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 Days**
(Specify whether
In this community **3**
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. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

9. (a) PRINT FULL NAME **Mrs. Mary Mills 420**

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

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

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

7. Birth date of deceased **May 26 1852**
(Month) (Day) (Year)

8. AGE: Years **87** Months **09** Days **17** If less than one day hr. _____ min. _____

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

10. Usual occupation **Housekeeper**

11. Industry or business _____

MOTHER FATHER
12. Name **Crabtree**
13. Birthplace **No record**
(City, town, or county) (State or foreign country)
14. Maiden name "
15. Birthplace **K**
(City, town, or county) (State or foreign country)

16. (a) Informant **Kansas City Convalescent Home**

(b) Address **7842 Marshall Rd. Kansas City, Mo.**

17. (a) **Interment, with father of dec.**
(Burial, cremation, or removal) (b) Date thereof **March 13, 1940**
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **J. Dale Walter**

(b) Address **7406 Marshall Rd.**

19. (a) **4-9-40** (b) **Mrs. J. Brennan**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **8th**
year **1940** hour **11** minute **20 AM.**

21. I hereby certify that I attended the deceased from **March 8 - 1940**
_____ 19____ to _____ 19____;

that I last saw her alive on **March 8** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Ischemic coarctation**

Due to **Senile atherosclerosis**

Due to **Arteriosclerosis**

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

Major findings: Of operations _____

Of autopsy _____

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? **311**

White at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **L. W. Yutt** (M. D. or other) **!**

Address **3150 Prairie** Date signed _____

Duration

not known

PHYSICIAN

Underline (the cause to which death should be charged statistically).

Brennan

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.....

Harlyn Rose

..... Licensed Embalmer No. *2810*

..... P. O. Address *7406 Cleveland*

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.