

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.

17 JUN 17 1940 399

1002

Registrar's No. 1850

Registration District No. _____

Primary Registration District No. _____

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 K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)
 In this community Life

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. 421 West 15th St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MARTHA ARMSTRONG *W.S.*

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

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

6. (b) Name of husband or wife Andrew Armstrong 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Febr. 7 1877
(Month) (Day) (Year)

8. AGE: Years <u>63</u>	Months <u>2</u>	Days <u>24</u>	If less than one day hr. _____ min.
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9. Birthplace Missour-1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Melvin Goldsby *6*

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

MOTHER FATHER { 14. Maiden name Susan Corie

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

16. (a) Informant's own signature Mr. Andrew Armstrong

(b) Address 421 W. 15th St. K. C. Mo.

17. (a) Burial (b) Date thereof May 3, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove Cemtery

18. (a) Signature of funeral director Rose & Henderson

(b) Address 4139 E. 15th St.

19. (a) May 3, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
 year 1940 hour 9 minute 15 A. M.

21. I hereby certify that I attended the deceased from 4-26-40, 19____, to 5-1-40, 19____; that I last saw her alive on 5-1-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of cervix with extension to bladder floor

Due to _____ 48

Due to _____

Other conditions Hydronephritis; Glomerular nephritis; Pulmonary congestion and edema
(Include pregnancy within 3 months of death)

Major findings: _____
 Operations _____
 Of autopsy See above

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 P. F. de Marna M.D. (M. D. or other) _____
 Address Supt. K. C. Gen. Hospital, K. C. Mo. Date signed _____

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

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.....

Van Lawson

working under my personal supervision.

Registered Apprentice No.

Signed *J. E. Anderson*

Licensed Embalmer No. *3657*

P. O. Address *K. C. Mo*

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.