

Registration District No. 209

Primary Registration District No. 1002

Registrar's No. 1952

FILED JUN 17 1940

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (c) Name of hospital or institution:  
916 Highland  
 (d) Length of stay: In hospital or institution 6-30  
 In this community since six years

3. (a) PRINT FULL NAME MARY WARD

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

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

6. (b) Name of husband or wife John Ward 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>2</u>	<u>2</u>	<u>hr.</u>

9. Birthplace Unknown

10. Usual occupation no work in state

11. Industry or business unknown

12. Name Thomaldayan

13. Birthplace Lake Creek Ga

14. Maiden name W

15. Birthplace Unknown

16. (a) Informant's own signature Mrs. Bolls

(b) Address 916 Highland

17. (a) Burial (b) Date thereof May 7 1940

(c) Place: burial or cremation Blue Ridge

18. (a) Signature of funeral director Dr. G. State

(b) Address 2102 W. State

19. (a) May 9, 1940 (b) \_\_\_\_\_

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (d) City or town Kansas City  
 (d) Street No. 916 Highland  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 30 year \_\_\_\_\_ hour \_\_\_\_\_ minute 10:30 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_, 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary thromboses (disseminated)

Due to Do not know

Other conditions Calcified hyalar gland with erosion, tuberculous in origin  
 Major findings: but non-active.

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? \_\_\_\_\_  
 (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 Russell (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

WRITE PRINTED IN 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.

**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.....  
P. O. Address.....

**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.**