

AUG 14 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

2682

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: St Marys Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution (Specify whether  
 In this community Non-Resident  
 years, months or days)

3. (a) PRINT FULL NAME William F. Alderson

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

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Addie Alderson 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased June 10 1860  
 (Month) (Day) (Year)

8. AGE: Years 80 Months 25 Days 25 If less than one day hr. min.

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

10. Usual occupation Special assessor

11. Industry or business Johnson Co Kas

12. Name Cress Alderson  
 13. Birthplace Virginia  
 (City, town, or county) (State or foreign country)

14. Maiden name No Record  
 15. Birthplace Virginia  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hospital Records  
 (b) Address City

17. (a) Burial (b) Date thereof July 7 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old the Kas.

18. (a) Signature of funeral director H.E. Julian  
 (b) Address Old the Kas

19. (a) July 5, 1940 (b) M. M. Groves  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson  
 (c) City or town Olathe  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 308 West Park Street.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5  
 year 1940 hour 2 minute 45 A. M.

21. I hereby certify that I attended the deceased from June 10 1940  
 \_\_\_\_\_, 19\_\_\_\_, to death July 5, 1940;  
 that I last saw him alive on July 4, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial exhaustion chronic  
 Due to Trans. Vascular Prost. Failure

Due to 92  
 Other conditions Haemia 1941  
 (Include pregnancy within 3 months of death)

Major findings: Enlarged Prost. Lobes  
 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?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address 1019 Prof. July 5 1940 signed \_\_\_\_\_

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. WHILE FILLING IN—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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**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.....

*H. E. Julien*

Licensed Embalmer No. ....

*2042*

P. O. Address.....

*Olathe Kas*

**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.**