

Registration District No. 399

Primary Registration District No. 1002

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

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. Convalescent Home 3200 Norledge  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 50 Yrs. years, months or days

3. (a) PRINT FULL NAME Mrs. Dolly Barclay Oakey

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

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

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

7. Birth date of deceased Feb. 1, 1866  
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Potsdam New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Barclay  
13. Birthplace Potsdam New York  
(City, town, or county) (State or foreign country)  
14. Maiden name Harriett Crossen  
15. Birthplace Potsdam New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. Woodward

(b) Address 2419 Olive

17. (a) Burial (b) Date thereof 8-4-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director W. M. Crave

(b) Address 1401 Brush Creek Blvd.

19. (a) AUG. 4, 1940 (b) W. M. Crave  
(Date received local registrar) (Registrar's signature)

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. 2419 Olive Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3rd  
year 1940 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from July 30  
1940, to August 27, 1940

that I last saw her alive on August 12, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Arteriosclerosis & Hypertension 82 10 years

Due to \_\_\_\_\_

Other conditions Right side hemiplegia from several strokes over last few years  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_  
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 3

23. Signature Dr. Robert C. Thompson (M. D. or other) DC

Address 714 Chambers Bldg. Date signed Aug 4, 1940

R. C. Shannon  
714 Chambers Bldg.  
Vi 3846

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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

*Kenneth Page Sipp*

Licensed Embalmer No. *4128*

P. O. Address. *1309 Canal Creek N.C.*

**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.**