

No. 2
-10-39
7-39
X21492

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3243**

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: **5106 Wabash** **2**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 days**
(Specify whether)
 In this community **23 yrs**
years, months or days

3. (a) PRINT FULL NAME **MARIE KABELLA PAYNE** **5M**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

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 **Dec 13 - 1873**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	66	8	1	hr. min.

9. Birthplace **England** **4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business
MOTHER FATHER
12. Name **George Hunt**
13. Birthplace **England**
(City, town, or county) (State or foreign country)
14. Maiden name **Marcella Hunt**
15. Birthplace **England** **4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Marcella Campbell**
(b) Address **5106 Wabash**

17. (a) Burial **(b) Date thereof** **Aug - 17 - 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Floral Hill**

18. (a) Signature of funeral director **Mrs. C. L. Foster**
(b) Address **718 Brooklyn**

19. (a) Aug. 16, 1940 **(b) M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
0
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5106 Wabash**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? **53** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **13th**
 year **1940** hour **12:00 M.** minute **M.**
21. I hereby certify that I attended the deceased from **8-10-40**
 , 19 to **8-13-40** , 19
 that I last saw her alive on **8-13-40** , 19
 and that death occurred on the date and hour stated above.

Immediate cause of death
CEREBRAL HEMORRHAGE
g d w

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

Major findings:
 Of operations
 Of autopsy **None**

Discretion
 PHYSICIAN
 Underlines 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
23. Signature **Dr. R. Shaw** (M. D. or other)
Med. Dir. K. C. Gen. Hospital, K. C. Mo. Date signed

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

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,

 , Registered Apprentice No.

working under my personal supervision.

Signed *Permit E. Browning*

Licensed Embalmer No. *2724*

P. O. Address *H. 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.