

2  
3-40  
7-39  
X23159

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3401

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: 3420 - E - 9th 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 Yrs  
years, months or days

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. 1000 Arker  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27  
year 1940 hour 8 minute 20 P. M.

21. I hereby certify that I attended the deceased from November 9th, 1938, to Aug 27, 1940;  
that I last saw her alive on Aug 27, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy

Due to: Hypertension

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
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 Chas S. Fry (M. D. or other) \_\_\_\_\_  
Address 539 Lee Bldg Date signed 8/28/40

Duration

2 yr.

?

PHYSICIAN

820

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Estella L. Vortman 635

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 Clarence E. Vortman 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased April - 3 1883  
(Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 24 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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

12. Name Asbury L. Watson

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

14. Maiden name Sarah Jane Steel

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

16. (a) Informant Clarence E. Vortman

(b) Address 1000 Arker

17. (a) Funeral (b) Date thereof Aug 29, 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt moriah

18. (a) Signature of funeral director Mrs. C. L. Foster

(b) Address 918 Brooklyn R.C. rmo

19. AUG. 29, 1940 (a) (Date received local registrar) (b) M. M. Crave (Registrar's signature)

MOTHER FATHER

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

10 hours  
per day -

**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.....

*Renzel C. Browning*

Licensed Embalmer No.....

*2726*

P. O. Address.....

*N.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, fact should be so stated above.