

2
3-40
7-39
X23159

Registration District No. 573

Primary Registration District No. 5551A

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Blue Springs Rural
(c) Name of hospital or institution: 2 1/2 Miles W Blue Springs
(d) Length of stay: In hospital or institution 50 Years
In this community 50 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Rural 2 Miles W Blue Springs
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Margaret Hiffner

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

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

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

7. Birth date of deceased Oct 24 1856

8. AGE: Years 83 Months 9 Days 0 If less than one day hr. _____ min. _____

9. Birthplace Bainbridge Ohio

10. Usual occupation Farmers House wife

11. Industry or business Retired

12. Name Tilbury Giffen

13. Birthplace Ohio

14. Maiden name Schenecker

15. Birthplace Germany

16. (a) Informant John L. Hiffner

(b) Address Blue Springs Mo

17. (a) Burial (b) Date thereof 7/26/40

(c) Place: burial or cremation Woodland Independence

18. (a) Signature of funeral director R. Blunt

(b) Address Blue Springs Mo

19. (a) Aug 23, 1940 (b) W. G. Rowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th year 1940 hour 12:00 minutes 30 P.M.

21. I hereby certify that I attended the deceased from Oct 2nd 1935 to July 24 1940 that I last saw her alive on July 24th 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis & perforation of gastro-intestinal - Carcinoma of the Liver

Due to 4 1/2 yrs Other conditions Dyspnea 98% total, reduced fracture of femur, surg. Major findings: neck - 1934 - none Of operations none Of autopsy No autopsy

Duration 48 hrs 6 yrs PHYSICIAN _____ 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 about 1934 (c) Where did injury occur? near Blue Springs Jackson Mo (d) Did injury occur in or about home, on farm, in industrial place, in public place? About the home

While at work? yes (Specify type of place) (e) Means of injury Due to a fall 23. Signature W. G. Rowe (M. D. or other) _____ Address Blue Springs Mo Date signed 8-21-40

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

MOTHER FATHER

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.....

R. Blurb

Licensed Embalmer No.....

2353

P. O. Address.....

Blue Springs, 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.