

NOV 1 1940
Primary Registration District No. **509**

Primary Registration District No. _____

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

1. PLACE OF DEATH: **Jackson**
 (a) County **Jackson**
 (b) City or town **Kansas City**
 (c) Name of hospital or institution: **7147 Grand Ave**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **32 years**
 In this community **32 years**
 years, months or days

3. (a) PRINT FULL NAME **Mrs. Elizabeth Musser Sprinkle**

3. (b) If veteran, name war **XX** 3. (c) Social Security No. **No**

4. Sex **Fe** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Clem C. Sprinkle** 6. (c) Age of husband or wife if alive **XX** years

7. Birth date of deceased **July 17 1854**
 (Month) (Day) (Year)

8. AGE: Years **86** Months **2** Days **12** If less than one day
 hr. min.

9. Birthplace **Worth County Va.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Adam Musser**

13. Birthplace **Worth County Va.**
 (City, town, or county) (State or foreign country)

14. Maiden name **Corrinna Wilson**

15. Birthplace **Worth County Va.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Miss Mollie M. Shipp**

(b) Address **7147 Grand**

17. (a) **Burial** (b) Date thereof **10-1-40**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills**

18. (a) Signature of funeral director **J. M. Wagner**
 (b) Address **Kansas City, Mo.**

19. (a) **10-1-40** (b) **M. M. Browe**
 (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. **7147 Grand Ave.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **29th**
 year **1940** hour **1:00** minute **P** M.

21. I hereby certify that I attended the deceased from **10 yr**
from Jan 19, 1930 to Sept 29, 1940
 that I last saw her alive on **Sept 29, 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Hypertensive Heart Disease with

Due to **Left heart failure**

Due to **Hypostatic pneumonia**

Other conditions **Senility** 95B

Major findings: Of operations _____
 Of autopsy _____

Duration

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 _____

(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 **E. N. Gentry** (M. D. or other)
 Address **915 Maple Bldg** Date signed **9-30-40**

Dr. E. N. Gentry

Argyle

HA 1577

24 Telephono

4-P. 2M

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 Cecil R Matthes

Licensed Embalmer No. 3807

P. O. Address K.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.