

JAN 8 1941

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **Research**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Non-Resident**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Sidgewick**
(c) City or town **Wichita**
(If outside city or town limits, write "RURAL")
(d) Street No. **✓**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **SADIE C. HELENA**

3. (b) If veteran, _____ name war _____ 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **April 14 1877**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	63	7	23	hr. _____ min. _____

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

10. Usual occupation **Housewife** **9**

11. Industry or business _____

12. Name **Frank Watts** **9**

13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Ellen Eldred**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Hospital Record**
(b) Address **Mo. Missouri**

17. (a) **Removed** (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

18. (a) Signature of funeral director **Wichita Mo.**
(b) Address **Kansas City, Kansas**
19. (a) **12-8-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **7**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **11/26/30**, 19____ to **Dec 7**, 19____
that I last saw her alive on **Dec 5**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction - Coronary embolism - Decomposition**
Due to **Hypertension & atherosclerosis**
Due to **Ch. Subarachnoid Hemorrhage**
Other conditions **131**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations **None**
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 **1**
23. Signature **[Signature]** (M. D. or other)
Address **H 800 E 24th St** Date signed **12/7/40**

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

FORM 1 X19311

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

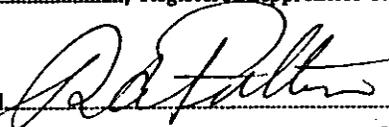
STATEMENT BY LICENSED EMBALMER

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. 3305

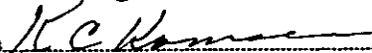
working under my personal supervision.

Signed



Licensed Embalmer No. 3305

P. O. Address



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.