

No. 2  
4-13-40  
1-17-39  
I X2315

JAN 8 1941

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4689

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

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: K. C. General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether)

In this community 25 yrs  
years, months or days)

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. 1632 Topping  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Anna Prutzman

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 Harvey Prutzman 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 17 1890  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>4</u>	<u>19</u>	hr. _____ min.

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

10. Usual occupation Housewife

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

12. Name James Black

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

14. Maiden name Myers

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

16. (a) Informant Harvey Prutzman

(b) Address 1632 Topping

17. (a) Burial (b) Date thereof Dec 9, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Wm C R Foster

(b) Address 918 Brooklyn

19. (a) 12-9-40 (b) M M Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6th  
year 1940 hour 12 min 10 P. M.

21. I hereby certify that I attended the deceased from 12-5-40, 19, to 12-6-40, 19, that I last saw her alive on 12-6-40, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Healed post operative mastectomy for Carcinoma of Breast with metastases to left lung

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

Due to 50

Other conditions Broncho and lobar pneumonia  
(Include pregnancy within 3 months of death)

Chronic passive congestion of liver

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy See above

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)  
(c) Means of injury 1

23. Signature Wm R. Horn (M. D. or other)  
Address Med. Dir. K. C. Gen Hospital Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**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 *me*

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*C. H. Wise*

Licensed Embalmer No.

*2570*

P. O. Address

*R. C. ms*

**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.**