

LEB JAN 8 1941

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4961**

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:
on way to Mercy Hospital in Car
(If not in hospital or institution, write street number or location) **3**
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Mary Ann Busick**

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

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

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

7. Birth date of deceased **Oct 7 - 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 2 21 hr. min.

9. Birthplace **Lees Summit Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Baby**

11. Industry or business **0**

12. Name **Annis Busick**

13. Birthplace **Miller Co. Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Pearl Crum**

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

16. (a) Informant **Annis Busick**

(b) Address **Lees Summit Mo.**

17. (a) **Burial** (b) Date thereof **12-30-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lees Summit Mo.**

18. (a) Signature of funeral director **H. B. Langford**

(b) Address **Lees Summit Mo.**

19. (a) **12-29-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Lees Summit**
(If outside city or town limits, write "RURAL")
(d) Street No. **417 So Market St**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **28-40**
year _____ hour _____ minute **1:10 P.** M.

21. I hereby [certify] that I attended the deceased from _____, 19____
and that death occurred on the date and hour stated above.
I am _____
Deputy Coroner

Immediate cause of death _____

Bronchopneumonia

Due to **Cerebral Edema**

Due to **101**

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 **5**

23. Signature **Russell W. Fox** (M. D. or other) _____
Address **502 1/2** Date signed _____

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

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

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.....

Licensed Embalmer No.....

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.