

Registration District No. **299**

Primary Registration District No. **1002**

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 No. 9**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Mo. & 17 days**
(Specify whether
In this community **1 Mo - 17 days**
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. **Los Angeles, California**
(If rural, give location)
(e) Citizen of foreign country? **D** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **18th**
year **1941** hour **4** minute **45 P.** M.
21. I hereby certify that I attended the deceased from
1-11-41 19... to **2-18-41** 19...
that I last saw her alive on **2-18-41** 19...
and that death occurred on the date and hour stated above.

Immediate cause of death
**Senile Dementia with Auricular
Fibrillation**

Duration

Due to _____
Due to _____
Other conditions
(Include pregnancy within 3 months of death)
90

PHYSICIAN

Major findings:
Of operations _____
Of autopsy **See above**
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) _____ Means of injury **D**
23. Signature **Dr. K. C. Thorn** (M. D. or other)
Address **Med. Dir. K. C. Gen. Hospital K. C. Mo.**

3. (a) PRINT FULL NAME **VEDA BOND**

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

4. Sex **F** 1 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if _____ years
7. Birth date of deceased **Feb 25 1879**
(Month) (Day) (Year)

8. AGE: Years **61** Months **11** Days **23** If less than one day: hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Joseph Fulks Ill**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Record Clerk**

(b) Address **K. C. Gen. Hosp**

(c) Date thereof **3-7-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **State Inst. Burial**

18. (a) Signature of funeral director **Thorn & Jolley**

(b) Address **Kansas City, Kansas**

19. (a) **3/23/41** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

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

48
38

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, fact should be so stated above.**