

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Jackson
 (c) Name of hospital or institution O'Henry Tubular
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 Days
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Jackson
 (c) City or town Westphalia 210
 (If outside city or town limits, write "RURAL")
 (d) Street No. 12
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME

Florence Barron

3. (b) If veteran, name war

No

3. (c) Social Security No. No

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased Dec 10 - 1889
 (Month) (Day) (Year)

8. AGE:

Years 51

Months 6

Days 8

If less than one day No
 hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country) Ind 1

10. Usual occupation

Home Wf

11. Industry or business

Home Wf

12. Name

Wm W. Barron

13. Birthplace

(City, town, or county)

(State or foreign country) 9

14. Maiden name

Wm W. Barron

15. Birthplace

(City, town, or county)

(State or foreign country) 9

16. (a) Informant's own signature Wm W. Barron

(b) Address 4021 W. 1st St

17. (a) Date of removal 6-18-41
 (Burial, cremation, or removal)

(b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation West Phalia Mo

18. (a) Signature of funeral director Wm W. Barron

(b) Address 118741 W. 1st St

19. (a) Date received local registrar

11/29/41

(b) Registrar's signature Wm W. Barron

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15 year 1941 hour 1:35 minute 15 M.

21. I hereby certify that I attended the deceased from June 8 to June 15, 1941; that I last saw her alive on June 15 and that death occurred on the date and hour stated above.

Immediate cause of death Obturator foramen fracture of femur
Operative abdominal June 8
adhesions
 Due to Colonic cancer
 Due to adhesions

Duration

Other conditions (Includes pregnancy within 3 months of death)

Major findings:

Of operations Peperation of colostomy of
 Of autopsy colostomy

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 Wm W. Barron (M. D. or other)
 Address 118741 W. 1st St Date signed

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

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.

100-1-1-39 1 X1931

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

G. E. Henderson

Licensed Embalmer No. *3657*

P. O. Address *H. G. 716*

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.