

FILED AUG 10 1941

Registration District No. 399

Primary Registration District No. 1002

048
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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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6-18-41-7-2-41
(Specify whether
In this community 24 years 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson **042**
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1820 E. 16th St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Fannie Turner

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

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 5 11 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>1</u>	<u>23</u>	hr. _____ min.

9. Birthplace Union Parish La. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Elijah Williams

13. Birthplace Union Parish La. 1
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Crenshaw

15. Birthplace Union Parish La. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof July 5-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation lined cemetery

18. (a) Signature of funeral director Frank M. Crowe

(b) Address 1905 1st St. St. Louis

19. (a) 7-5-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 2
year 41 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from 6-18- 1941 to 7-2- 1941,
that I last saw her alive on 7-2- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy

Due to Hypertensive Type of Heart Disease

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

Major findings: Of operations _____
Of autopsy _____

Duration _____
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 M. M. Crowe M. D. or other) 0
Address 1905 1st St. St. Louis Date signed 7-3-41

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.....

C. H. West

Licensed Embalmer No. 2710

P. O. Address.....

Kansas City

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.