

FILED SEP 12 1941

Registration District No. 279

Primary Registration District No. 1002

Registrar's No. 3095

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 7-9-41-8-4-41
(Specify whether years, months or days) 0

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. 626 Troost
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HAZEL HOWARD

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 M
(b) Name of husband or wife William Howard 6. (c) Age of husband or wife if alive 19 1/2 years
7. Birth date of deceased Dec 25 1921
(Month) (Day) (Year)

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

9. Birthplace Paris Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

MOTHER FATHER { 11. Industry or business _____

12. Name Basil Carter

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

14. Maiden name Deceased

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

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 8-16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seeds Mo

18. (a) Signature of funeral director Jungling McCoy

(b) Address 1513 Troost

19. (a) 8/16/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4
year 1941 hour 7 minute 50 a.m.

21. I hereby certify that I attended the deceased from 7-9-41
_____, 19____, to 8-4-41 19____;
that I last saw her alive on 8-4-41 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized peritonitis Duration _____

Due to Colon Bacillus Abscess

Due to Ruptured right ureteral stone

Other conditions + 3/4 in
(Include pregnancy within 3 months of death)

Major findings: Of operations Peritoniteal inflammatory fluid
Of autopsy Ruptured rt. ureter with abscess & peritonitis 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 J. G. Osburn (M. D. or other) _____
Address Gen Hos H-2 Date signed 8/15/41

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

ST 2
ST 8

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 *B. L. Luahem*

Licensed Embalmer No. *2540*
P. O. Address. *2208 Pine St*

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.