

FILED OCT 13 10 49
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3509

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:
Trinity Lutheran Hospital()
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 17 years (Specify whether
In this community. 17 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Jackson 48
(c) City or town. Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2025 Summit 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept- day 18
year 1941 hour 6 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from Aug 31 1941 to Sept-18 1941
that I last saw her alive on Sept-18 1941
and that death occurred on the date and hour stated above.

Immediate cause of death:
Acute Myocarditis
Acute Pulmonary Edema

Due to _____
Due to _____

Other conditions: ruptured left-tubal ovarian
(Include pregnancy within 3 months of death) abscess

Major findings:
Of operations _____
Of autopsy. See above.

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. C.M. Counsel (M. D. or _____)
Address. 208 W 17th St Date signed 9/20/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Violet Koup
3. (b) If veteran, name war. no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Married
6. (b) Name of husband or wife. Albert Grant Koup 6. (c) Age of husband or wife if alive. 23 years
7. Birth date of deceased. February 9, 1920
(Month) (Day) (Year)

8. AGE: Years 21 Months 7 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Akron, Ohio (City, town, or county) (State or foreign country)
10. Usual occupation At Home

11. Industry or business _____
12. Name Ernest Sinclair
13. Birthplace Colorado (City, town, or county) (State or foreign country)
14. Maiden name Mae Souza
15. Birthplace Mass. (City, town, or county) (State or foreign country)

16. (a) Informant Albert Grant Koup
(b) Address 2025 Summit
17. (a) Burial (b) Date thereof 9-22-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation. Mt. Hope Cemetery
18. (a) Signature of funeral director J. J. & T. J. Co.
(b) Address Kansas City, Mo.
19. (a) 9-21-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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. 4097

P. O. Address K.C. Mo.

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.