

Registration District No. 399

Primary Registration District No. 1002

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 K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether)

In this community 30 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Olive Carter Steele,

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female | 5. Color or race White

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

6. (b) Name of husband or wife Bayless Steele,

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

7. Birth date of deceased October 26 1874
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 21 If less than one day 0
hr. min.

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

10. Usual occupation at home,

11. Industry or business X

12. Name William H. Carter,

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

14. Maiden name Ada B. Campbell,
(City, town, or county) (State or foreign country)

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

16. (a) Informant Thomas Hill,

(b) Address 1010 East 11th St., K. C., Mo.

17. (a) Removal, (b) Date thereof 12-18-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dover, Missouri,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Dec. 18 1941 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁰⁴⁸

(c) City or town Kansas City ⁸
(If outside city or town limits, write "RURAL")

(d) Street No. 1010 East 11th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? X ¹⁰ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16th
year 1941 hour 5 minute 10 P. M.

21. I hereby certify that I attended the deceased from 12-11-41, 1941, to 12-16-41, 1941;
that I last saw her alive on 12-16-41, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE

Due to _____

Due to _____

Other conditions 42K
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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 0

23. Signature Dr. R. J. Shon (M. D. or other) _____
Address Med. Dir. K. C. Gen. Hospital Date signed 12-17-41

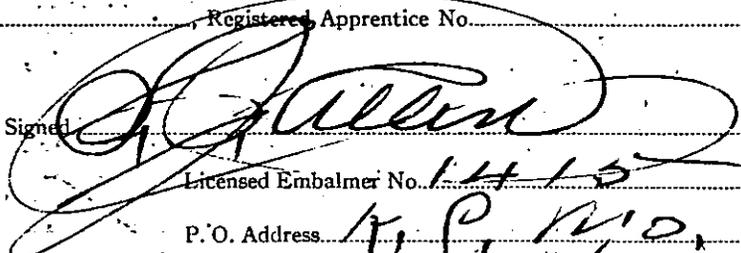
Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. 1415
P.O. Address N. S. No.

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.