

FILED MAR 9 1942

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 508

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

1. PLACE OF DEATH: Jackson
 (a) County Kansas
 (b) City or town City
 (c) Name of hospital or institution: A.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
 In this community at least 6 yrs
 years, months or days)

3. (a) PRINT FULL NAME ROSE GARDNER
 (b) If veteran, name war no
 (c) Social Security No. no

4. Sex Female 5. Color of race White
 6. (a) Single, widowed, married, divorced Single
 (b) Name of husband or wife _____
 (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 10 1868
 (Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 24
 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Gambourne

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

14. Maiden name Gambourne

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

16. (a) Informant Record Clerk

(b) Address A.C. Gen. Hosp. 1

17. (a) Removal (b) Date thereof 2-9-42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial

18. (a) Signature of undertaker Wm. A. Johnson
 (b) Address City

19. (a) 2/9/42 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1614 North Monroe
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4th
 year 1942 hour 5 minute 40 A. M.

21. I hereby certify that I attended the deceased from 1-25-42, 19____, to 2-4-42, 19____;
 that I last saw her alive on 2-4-42, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis with uremia

Due to Hypertension
1310

Due to _____
 Other conditions (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? _____

(Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature Henry R. Thom (M. D. or other) _____
 Address Med. Dir. K.C. Gen. Hospital Date signed _____

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.....

Wm. A. Johnson

Licensed Embalmer No.

3089

P. O. Address.....

K. E. 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.