

Registration District No. 399

Primary Registration District No. 1002

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 7 days  
(Specify whether years, months or days)  
 In this community 4 years

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")  
3025 Jerome  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Hannah Frances Ault Fear

20. DATE OF DEATH: Month July day 4th  
 year 1942 hour 9 minute 15 A.M. M.

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

21. I hereby certify that I attended the deceased from 6-27-42 19\_\_\_\_ to 7-4-42 19\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

that I last saw her alive on 7-4-42 19\_\_\_\_ and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife James Fear 6. (c) Age of husband or wife if alive 46 years

Immediate cause of death Chronic gomerular Nephritis; Hypertensive Heart Disease with decompensation

7. Birth date of deceased June 3rd, 1894  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>1</u>	<u>1</u>	hr. _____ min _____

Due to \_\_\_\_\_

Due to 131B

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

Other conditions (include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Charles E. Ault

Of autopsy See above

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

14. Maiden name Martha Mobley

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

16. (a) Informant Record Clerk  
 (b) Address K.C. General Hospital, K.C. Mo.

17. (a) Burial (b) Date thereof July 6th, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Mrs. C. L. Forster  
 (b) Address K.C. Mo.

19. (a) 7-6-42 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_

(d) Means of injury \_\_\_\_\_

23. Signature Dr. K. C. General Hospital (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 7-6-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

*Theron B. Redmon*

Licensed Embalmer No. *2737*

P. O. Address.....

*H. P. 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.**