

FILED JUL 27 1942  
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2731

48  
00303  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Jackson

(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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4.5 months  
(Specify whether years, months or days) 2 months

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.") 8

(d) Street No. 3005 Mc Gee  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country. \_\_\_\_\_

3. (a) PRINT FULL NAME Gertrude Marie Nithman

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. Single

6. (b) Name of husband or wife. \_\_\_\_\_

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

7. Birth date of deceased. Nov. 26, 1941  
(Month) (Day) (Year)

8. AGE: Years 0 Months 7 Days 30 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace. Des Moines, Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation. none

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

MOTHER FATHER { 12. Name. Le Roy Nithman

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

14. Maiden name. Arlene Olson

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

16. (a) Informant. Le Roy Nithman

(b) Address. 3005 Mc Gee

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof. 7-17-42  
(Month) (Day) (Year)

(c) Place: burial or cremation. Des Moines, Iowa

18. (a) Signature of funeral director. Freeman Mortuary

(b) Address. Kansas City, Missouri

19. (a) 7-17-42 (Date received local registrar)

(b) M. M. Grome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 16  
year 42 hour 5:20 min P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death. Fracture of the skull  
Duration \_\_\_\_\_

Due to. Fall from window, 3rd floor.

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

Other conditions. 1862  
(Include pregnancy within 3 months of death) 16

Major findings: \_\_\_\_\_

Of operations. \_\_\_\_\_

Of autopsy. Sufora

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in as follows:

(a) Accident, suicide, or homicide (specify). Accident

(b) Date of occurrence. 7/14/42 123

(c) Where did injury occur? 3005 Mc Gee  
(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)

(c) Means of injury. \_\_\_\_\_

23. Signature. M. M. Grome (M. D. or other) 7/17/42

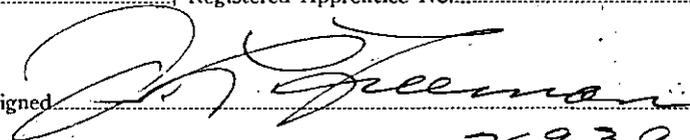
Address. \_\_\_\_\_ Date signed. 7/17/42

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**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. 2939

P. O. Address H. C. 210

**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.**