

Registration District No. **149**

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 Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Willows Hospital-2929 Main St 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 hrs 55 min.**
(Specify whether
In this community **same**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **2929 Main St**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Judith Larsen.**
3. (b) If veteran, name war **babe**
3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **babe**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Jan 3 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 12 hr. 55 min.

9. Birthplace **Kansas City Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)

14. Maiden name **Hilda Larsen**

15. Birthplace **Superior Wisconsin. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Willowson**

(b) Address **2929 Main St.**

17. (a) **Burial** (b) Date thereof **Jan. 6-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **Eylar Funeral Home**

(b) Address **1800 Linwood K.G. Mo.**

19. (a) **1-6-43** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **3 rd**
year **1943** hour **8:55 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **Jan 3**
_____, 19**43**, to **Jan 3**, 19**43**;

that I last saw her alive on **Jan 3**, 19**43**;
and that death occurred on the date and hour stated above.

Immediate cause of death **premature 6 mo gestation** Duration
Twin # 2

Due to **Edema of Mother** 159

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 **H. L. Dwyer D.** (M.D. or other)

Address **315 Alameda Rd.** Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{not} ~~was~~ embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Chas W. Ks

Licensed Embalmer No.....

2644

P. O. Address.....

1800 Linwood

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.