

FILED MAR 5 1943

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 1006

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:  
1614 Wyandott  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether  
 In this community 25 Years (Specify whether  
 years, months or days)

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")  
 (d) Street No. 1614 Wyandotte  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Martha Virginia Percell  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Feb day 23rd  
 year 1943 hour about 4:00 minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from Jan 15  
1943 to Feb 23, 1943  
 that I last saw h. r. t. alive on Feb 18, 1943  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Donald A. Percell  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased May 21 1877  
 (Month) (Day) (Year)

Immediate cause of death Leucovor ataxia  
 Duration 6 mos

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>8</u>	<u>18</u>	<u>2</u> hr. _____ min.

Due to Pericerebral Hemorrhage about 6  
30  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

9. Birthplace Platte Co. Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation at Home

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

12. Name Nichell Coffrey

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

14. Maiden name Camanda Holden Wilcox  
La.

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

16. (a) Informant Grace M. Wilcox

(b) Address 1614 Wyandotte

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-43  
 (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys

18. (a) Signature of funeral director Mrs. C. L. Forster  
 (b) Address 918 Brooklyn

19. (a) 2-26-43 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

PHYSICIAN  
 Major findings: Of operations non  
 Of autopsy non  
 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 M. M. Browne (M. D. or other) \_\_\_\_\_  
 Address 906 Grand Ave Date signed 2-23-43

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

MOTHER FATHER

Dr. Lane  
vi. 3154  
906 Grand

824-28

**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 A. Redmon*  
Licensed Embalmer No. 2737  
P. O. Address *F. R. 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.**