

ED. MAY 6 1943
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
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2917 Forest
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
15 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. 2917 Forest
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Laura Belle Oliver

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 Widowed

6. (b) Name of husband or wife..... Unknown

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

7. Birth date of deceased. September 21 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>	<u>7</u>	<u>6</u> hr. min.

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

10. Usual occupation None

11. Industry or business.....

MOTHER FATHER { 12. Name Joseph M. Hasting

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

14. Maiden name Edith F. McLennan

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

16. (a) Informant Miss Alleyn Oliver

(b) Address 2917 Forest

17. (a) Removal (b) Date thereof 4-29-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stafford, Kansas

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 4-28-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from 3-23
1943, to 4-27, 19 43
that I last saw her alive on 4-27, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Malignant phase of essential arterial hypertension. Duration Two weeks

Due to Essential Arterial hypertension. Years 10

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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) (c) Means of injury.....

23. Signature [Signature] (M. D. or other)

Address [Signature] Date signed 4/28/43

08-08-11
1130-5100
41-6708
WALLINGTON, N.C.
11/13/11

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 Clarence H. Chiles

Licensed Embalmer No. 3473

P. O. Address: 56 E 760

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.