

FILED MAY 1944
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: 3427 E 9
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 49 days (Specify whether in this community 49 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Jackson ⁴⁸

(c) City or town Kansas City ^F
(If outside city or town limits, write "RURAL")

(d) Street No. 3427 E 9th
(If rural, give location)

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

3. (a) PRINT FULL NAME Ida Hubbard Riggs

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 18
year 1943 hour 9 minute 30 M.

21. I hereby certify that I attended the deceased from January 16, 19 43 April 17, 19 43
that I last saw him alive on April 10, 19 43
and that death occurred on the date and hour stated above.

4. Sex Fe

5. Color or race wh

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Bertrand

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

7. Birth date of deceased June 18 1862
(Month) (Day) (Year)

Immediate cause of death Endocarditis Chronic

Due to Paralysis Agitans ⁹²⁸ 10 Yrs

Due to Senility 10 Yrs

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

8. AGE: Years 80 Months 10 Days 0
If less than one day _____ hr. _____ min.

9. Birthplace N. H. I.
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy none

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name Joseph Hubbard

13. Birthplace no record ⁹
(City, town, or county) (State or foreign country)

14. Maiden name no record ⁹

15. Birthplace no record ⁹
(City, town, or county) (State or foreign country)

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 0

23. Signature Calvin A Beard (M. D. or other) _____
Address 2307 Bryant Blvd Date signed _____

16. (a) Informant Miss Felicia Colburn

(b) Address 3427 E 9th

17. (a) Burial (b) Date thereof April 21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Mrs. C. F. Foster

(b) Address N. O. no

19. (a) 4-20-43 (b) M. W. Brown
(Date received local registrar) (Registrar's signature)

Project 12/19/99
Ha 2824

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.....

P. O. Address.....

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.