

FILED JUN 7 1943  
Registration District No. **199**

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: DeLore Rest Home, 622 Benton  
(If not in hospital or institution, write street number or location)

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

In this community ten days  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Katherine Ward Denney

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female 5. Color or race cauc

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

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

7. Birth date of deceased: December 20 1864  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>78</u>	<u>4</u>	<u>24</u>	hr. min.

9. Birthplace: Dresden Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

**MOTHER FATHER**

12. Name Andrew Ward

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Hannah McEadden

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

16. (a) Informant Hannah M. West

(b) Address Holden, Missouri.

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

(b) Date thereof May 18, 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Holden Missouri

18. (a) Signature of funeral director Canada & Ropp

(b) Address Holden, Missouri.

19. (a) May 17 1943 (Date received local registrar)

M. M. Crome (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Johnson 31

(c) City or town Holden 1  
(If outside city or town limits, write "RURAL")

(d) Street No. no number  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country XX

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 14  
year 1943 hour 6:15 minute P M.

21. I hereby certify that I attended the deceased from Dec 22  
19 42 to May 14 19 43  
that I last saw h. or alive on May 6 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Endocarditis

Due to Chronic Myocardial Degeneration

Due to Chronic Nephritis

Other conditions (Include pregnancy within 3 months of death) 131B

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations

Of autopsy

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 Shirley Holmberg (M.D. or other)

Holden Mo Address Date signed 5/15/43

---

---

**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.**