

FILED OCT 13 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 Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Little Sisters of the Poor. 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 Yrs. 5 Months.**
(Specify whether 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. **5331 Highland Ave.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Catherine HUNTER.**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **White**

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **April 9th, 1862**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	5	17	hr. _____ min.

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

10. Usual occupation **Invalid in Convalescent**

11. Industry or business **Home**

12. Name **Thomas Smith.**

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

14. Maiden name **Mary Black**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Sister St. Thiele.**

(b) Address **5331 Highland Ave.**

17. (a) **Removal** (b) Date thereof **9-28-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Paris Texas**

18. (a) Signature of funeral director **Melody-McGilley**
K. C. Mo.

19. (a) **9-28-43** (b) **J E Brown, Dep**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **26th**
year **1943** hour **3** minute **A. M.**

21. I hereby certify that I attended the deceased from **Sept 26**, 1943, to **Sept 26**, 1943; that I last saw her alive on **Sept 22**, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial pneumonia**

Due to **Myocardial infarction**

Due to **arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death) **93e 2**

Major findings: Of operations **no**

Of autopsy **no**

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) Means of injury _____

23. Signature **Dr. John T. Schweitzer** (M. D. or other) **MD**

Address **1402 Bryant Bldg** Date signed **9-27-43**

Duration **6 days**

1 year

years

PHYSICIAN

Underline the cause to which death should be charged statistically.

K. E. M. O.

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. 2999
P. O. Address..... KC

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.