

Registration District No. **1002**

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: in hospital or institution 2 mos. 2 days
(Specify whether
 In this community 15 yrs
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. 2918 Harrison
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Clara Cole

3. (b) If veteran, name war AND **3. (c) Social Security** No. None

4. Sex F **5. Color or race** W **6. (a) Single, widowed, married, divorced** Divorced
6. (b) Name of husband or wife Wm H. Cole **6. (c) Age of husband or wife if alive** 76 years
7. Birth date of deceased March 30, 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 19 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Homemaker

11. Industry or business None

MOTHER FATHER

12. Name Wm. Browne

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

14. Maiden name Unknown

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

16. (a) Informant Cora Carter

(b) Address 624 W 40th St

17. (a) (Burial, cremation, or removal) Reburied **(b) Date thereof** 10-21-43
(Month) (Day) (Year)

(c) Place: burial or cremation Challicothe Mo

18. (a) Signature of funeral director D. E. Brown

(b) Address Mo

19. (a) (Date received local registrar) 10-20-43 **(b) (Registrar's signature)** D. E. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 19th year 1943 hour 6 minute 20 A. M.

21. I hereby certify that I attended the deceased from August 17th 1943 to Oct. 19th 1943
 that I last saw her alive on Oct. 19th 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of right hip (accidental fall in home)

Due to _____

Due to 186a

Other conditions 78
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Aug 17, 1943

(c) Where did injury occur? 2918 Harrison
(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 Fall

23. Signature Drury K. Thom **(M. D. or other)** _____

Address Gen'l Hosp. **Date signed** 10-19-43

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

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..... *H. D. Blackman*

Licensed Embalmer No. *3639*

P. O. Address..... *H. C. 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.