

NOV 1 1943/49
Registration District No. _____

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: Mrs. Russell Rest Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution about 1 yr.
(Specify whether years, months or days)

In this community 17 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 3322 Wabash
(If rural, give location)

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

3. (a) PRINT FULL NAME Nellie Hutchinson

3. (b) If veteran, name war none

3. (c) Social Security No. no

4. Female 5. Color of hair White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased 2-20-1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>8</u>	<u>1</u>	_____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER

12. Name unknown

13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Howard E. Hutchinson

(b) Address Howard Hotel, Kansas City, Mo.

17. (a) Burial (b) Date thereof 10-24-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park

18. (a) Signature of funeral director Johnston

(b) Address W. C. I. S.

19. (a) 10-23-43 (b) D-E Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 21
year 43 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 1
1943 to 10-21, 1943,
that I last saw her alive on 4-30, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis

Due to _____

Due to 930

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
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 John H. Moreland (M. D. or other) MD
Address 520 Commercial Bldg Date signed 10-23-43

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. *8798*

..... P. O. Address *N. C. / C.*

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.