

FILED DEC 3 1943 49

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 4813

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: Lakeside Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hours  
(Specify whether \_\_\_\_\_)

In this community 37 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 509 Cypress  
(If rural, give location) 8

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME MAGGIE SHERRICK NATTIER

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex fe.

5. Color or race white

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

6. (b) Name of husband or wife Oliver Milton

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased FEB. 21, 1881  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>8</u>	<u>21</u>	hr. _____ min.

9. Birthplace \_\_\_\_\_ Pa. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business none

MOTHER FATHER {

12. Name Abram Rice

13. Birthplace Uniontown Pa. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Sherrick

15. Birthplace \_\_\_\_\_ Pa. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Oliver M. Nattier

(b) Address 509 Cypress

17. (a) Burial (b) Date thereof Nov. 15, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address Kansas City, Mo.

19. (a) 11-15-43 (b) M. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 12  
year 1943 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Obstruction  
in ilio-cacum

Due to Mechanical obstruction Duration 19 min

Due to Strangulation

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Gangrene of 10 inches of terminal ileum  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature L. J. Graham (M. D. or other) DO  
Address 811 Chamber Bldg Date signed 11-17

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

De. 11/10

**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 W. D. Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. Mo

**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.**