

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: Polyclinic Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 minutes
(Specify whether
 In this community 7 Months
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. 519 Montgall
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME EDNA CHARLENE BLACK

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 Single

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

7. Birth date of deceased April 14 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 18 hr. min

9. Birthplace Polyclinic Hosp. Kansas City, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business None

12. Name David L. Black

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

14. Maiden name Roberta Pettit

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

16. (a) Informant David L. Black

(b) Address 519 Montgall

17. (a) Burial (b) Date thereof 1/3/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

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

(b) Address Kansas City, Mo.

19. Jan 3 1944 (b) J. B. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2
 year 1944 hour 10 minute A. M.

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

Immediate cause of death Pneumonia
 Duration _____

Due to _____ 107

Due to _____
 Other conditions Lipid arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See form

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)
 (e) Means of injury _____

23. Signature J. B. Brown 3 1/2/44
(Date signed)

Address _____

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.....

A. D. Blackman

Licensed Embalmer No.

3639

P. O. Address.....

N. E. 7th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.