

FILED FEB 2 1944
Registration District No.

Primary Registration District No. **1002**

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:
General Hospital No. 2 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8-19-43-1-10-44**
(Specify whether years, months or days)
In this community **Unknown**

3. (a) PRINT FULL NAME **GERTRUDE CARTER**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **Negro**
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 **March 27 1909**
(Month) (Day) (Year)

8. AGE: Years **34** Months **9** Days **14**
If less than one day _____ hr. _____ min.

9. Birthplace **Fort Smith Ark.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER { 12. Name **Manuel Carter**
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name **Teanie Nicks**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
(b) Address **General Hospital No. 2**

17. (a) **Burial** (b) Date thereof **1/17/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ft. Smith, Ark.**

18. (a) Signature of funeral director **H. B. Moore**
(b) Address **1820 E 18th St.**

19. (a) **Jan 15, 1944** (b) **J. E. Brown**
(Date received local registrar) (Registrar's signature)

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. **1816 Grove**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **10**
year **1944** hour **8:30** minute **A.** M.
21. I hereby certify that I attended the deceased from **August 19**
1943 to **January 10**, 19 **44**
that I last saw her alive on **January 10**, 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Advanced Pulmonary Thc. with Psychosis** Duration _____

Due to _____
Due to **13th** _____
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 anatomically)

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 **J. E. Brown** (M. D. or other)
Address **Tex. Hwy. #2 600622** Date signed **1/13/44**

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 me

AB Moore

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

AB Moore

Licensed Embalmer No. _____

2410

P. O. Address _____

1820 E 18th

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.