

FILED FEB 10 1944

Registration District No. 100

Primary Registration District No. 100

Registrar's No.

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:
Home-7410 East 15th. St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 23 years (Specify whether 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. 7410 East 15th. St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

Sophia V. Key

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe. 5. Color or race WA 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Theodore Key 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased May 1st. 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 8 5hr.min.

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

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Chance Shepard

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

14. Maiden name Ira Hart

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

16. (a) Informant Mr Theodore Key

(b) Address 7410 East 15th. St.

17. (a) Burial (b) Date thereof 1/29/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cem

18. (a) Signature of funeral director Earp Funeral Home

(b) Address Kansas City Missouri

19. (a) 1-28-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26 th
year 1944 hour 10 minute 15 P M.

21. I hereby certify that I attended the deceased from Jan 25 th 1944, to Jan 26 th 1944;
that I last saw her alive on Jan 26 th 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Duration 2 wks

Due to Acute Endocarditis 6 hrs

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy..... 918

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?

(Specify type of place) While at work? (e) Means of injury.....

23. Signature Dr. A. L. Pickens M.D. or other DO
Address 6423 East 15th St. P. Mo Date signed 1-27-44

WRITE PLAINLY—USE UNFADING INK

MOTHER FATHER

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..... *John B. Camp*
Licensed Embalmer No... *2955*
P. O. Address... *1100 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.