

FILED FEB 10 1944

Registration District No. **149**

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:
3231 Prospect
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days** (Specify whether
In this community **3 years**, (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Samuel Withrow McPherson**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **no**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Martha McPherson**
6. (c) Age of husband or wife if alive **dec.** years
7. Birth date of deceased **July 27 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 5 30 hr. min.

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

10. Usual occupation **Retired**

11. Industry or business **X**

12. Name **James W. McPherson**

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

14. Maiden name **Mary J. Shanklin**

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

16. (a) Informant **Miss Kathryn McPherson**
(b) Address **1400 E. Linwood, Kansas City, Mo.**

17. (a) **removal** (Burial, cremation, or removal) (b) Date thereof **1-27-44**
(Month) (Day) (Year)

(c) Place: burial or cremation **Des Moines Ia**

18. (a) Signature of funeral director **Stine McClure**
(b) Address **11tham Plaza K.C. Mo**

19. (a) **1-26-44** (Date received local registrar) (b) **T. E. Brown** (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. **1034 Paseo**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **26th**
year **1944** hour **1:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **Jan 23**
Jan 30, 19**44** to **Jan 29**, 19**44**
that I last saw her alive on **Jan 25**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Haemorrhage
Left Side Paralysis

Due to **830'**
Cerebral Haemorrhage
Other conditions **Cerebral Haemorrhage**
(Include pregnancy within 3 months of death)

Major findings: **No. of operations** **No. of autopsy** **No.**

Duration
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) **No**
(b) Date of occurrence **Jan 22**
(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) Means of injury
23. Signature **T. E. Brown** (M.D. or other)
Address **309 210 St** Date signed **1-26-44**

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

MOTHER FATHER

Dr. K. P. Jones

804 E. 10

St. Louis, Mo.
4242 Grand

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

E. M. Plank

Licensed Embalmer No.

7848

P. O. Address

W. 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.