S. No. 2
M—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1944

Registration District No. 799

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6404

Primary Registration District No. 1002

Registrar's No. 712

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: K. C. General Hospital No. 1 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day, 19 hrs. (Specify whether years, months or days)

In this community 22 Yrs.

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.: 6104 Indiana (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country: 0

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3. (a) PRINT FULL NAME: Ada Madeleine Wise

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: Wh

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

6. (b) Name of husband or wife:

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

7. Birth date of deceased: May 5, 1882 (Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 6 If less than one day hr. min.

9. Birthplace: New York City (City, town, or county) New York (State or foreign country)

10. Usual occupation: At Home

11. Industry or business:

MOTHER FATHER

12. Name: William B. Sparry

13. Birthplace: No Record (City, town, or county) New York (State or foreign country)

14. Maiden name: Catherine A. Goodwin

15. Birthplace: No Record (City, town, or county) New York (State or foreign country)

16. (a) Informant: Henry A. Colwell

(b) Address: 6104 Indiana

17. (a) Forest Hill Cem (Burial, cremation, or removal) (b) Date thereof: 2/14/44 (Month) (Day) (Year)

(c) Place: burial or cremation: Forest Hill

18. (a) Signature of funeral director: Gates Funeral Home

(b) Address: 1901 Olathe Blvd. K.C. Kans.

19. (a) 2-12-44 (Date received local registrar) (b) H. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 11 year 1944 hour 6 minute 10 A. M.

21. I hereby certify that I attended the deceased from February 9, 1944 to February 11, 1944 that I last saw h er alive on February 11, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Bilateral Lobar pneumonia

Duration

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:

Of operations:

Of autopsy: See above

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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: 0

23. Signature: A. E. Upsher (M. D. or other) M.D.

Address: Med. Dir. Gen'l Hosp. Date signed: 2-11-44

(Licensed Embalmer's Statement on Reverse Side)

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.....Wm L. Ward

Licensed Embalmer No.....3991

P. O. Address.....309 E. 67 St

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.)

K.C. Mo.

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