

FILED MAY 11 1948  
Registration District No. 197

Primary Registration District No. 1002

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

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:  
St. Marys Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4-12-44-5-2-44  
(Specify whether 1 yr.)

In this community 1 yr.  
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. 814 Troost  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Belle Matthews

3. (b) If veteran, name war No

3. (c) Social Security No. 487-10-4079

4. Sex Female / race White

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ollie James Matthews

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Feb. 6 1889  
(Month) (Day) (Year)

8. AGE: Years 55 Months 2 Days 26  
If less than one day  
hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Thomas D. Allen

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

14. Maiden name Katie Garrett

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

16. (a) Informant Mr. Ollie James Matthews

(b) Address 814 Troost

17. (a) Removal (b) Date thereof May 5-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Topeka, Kansas

18. (a) Signature of funeral director William Roe

(b) Address Kansas City, Mo

19. (a) 5-4-44 (b) W. E. Brown  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 4-30-44  
19\_\_\_\_ to 5-2-44 19\_\_\_\_  
that I last saw her alive on 5-2-44 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to Carcinoma of Pancreas

Due to \_\_\_\_\_  
Other conditions 46g  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Carcinoma of Pancreas

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 Robert W. Smith (M. D. or other) \_\_\_\_\_  
Address 2800 Main Date signed 5-4-44

**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.....

*Harlan Roe*

Licensed Embalmer No. 2810

P. O. Address H. E. 226

**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.**