

FILED MAY 1 1944
799

Registrar's No. 1635

Registration District No. _____

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:
WOODS REST HOME - 2704 TRACY AVENUE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 WEEKS
(Specify whether
In this community 55 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY ²⁴
(c) City or town LIBERTY ³
(If outside city or town limits, write "RURAL") ¹
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MR. CULLEN EVERETT OTT

3. (b) If veteran, name war NO 3. (c) Social Security No. 499-16-3361

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 3 DIVORCED

6. (b) Name of husband or wife MRS. FRANK A. WILSON 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased DECEMBER 14 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 3 Days 28 27 hr. _____ min.

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

10. Usual occupation FILING STATION OPERATOR

11. Industry or business _____

12. Name FREDRICK OTT

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

14. Maiden name SARAH JANE RENFRO

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

16. (a) Informant MRS. LULU KASIAH

(b) Address 2921 EUCLID AVENUE

17. (a) CREMATION (b) Date thereof APRIL 13 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMER'S SONS

18. (a) Signature of funeral director D.W. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 4-13-44 (b) T. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 11TH
year 1944 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from 2-6 1944 to 4-11 1944
that I last saw him alive on 4-11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to _____

Other conditions J 3a!
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

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

23. Signature George C. Dea (M. D. or other) _____

Address 1630 Prof Bldg Date signed 4/24/44

1638
11-3
Professional Embalmers

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: *C. O. M. W. H. E. Y*
Licensed Embalmer No. *1767*
P. O. Address *Kansas City 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.