

FILED MAY 29 1944

Registration District No. _____

Primary Registration District No. 5289

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Clay
(b) City or town RR # 10 NO-KAN-CITY MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: AT HOME / JAWAHIR
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 65 years - (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County CLAY
(c) City or town NORTH KAN CITY MO
(If outside city or town limits, write "RURAL")
(d) Street No. RR # 10 (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARGARET-JANE-ROBERTSON

3. (b) If veteran, name war NO (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept - 21 - 1846
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
97 - 7 - 13 hr. min.

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

10. Usual occupation HOUSE - WIFE

MOTHER FATHER

11. Industry or business _____
12. Name ISAAC - WALKER -

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

14. Maiden name KATHRINE PARKINSON
15. Birthplace SCRANTON PA
(City, town, or county) (State or foreign country)

16. (a) Informant I - A - ROBERTSON
(b) Address R.R. # 10 NO-KAN-CITY MO

17. (a) BURIAL (b) Date thereof 5-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Manhattan Kan

18. (d) Signature of funeral director MORTON FUNERAL H
(b) Address NO-KAN-CITY-MISSOURI

19. (a) May 8 1944 (b) Ruth N Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 6th
year 1944 - hour 7 minute a M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her ER alive on _____, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Pneumonia Duration 2 days

Due to Senility

Due to _____

Other conditions no
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

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) (e) Means of injury _____

23. Signature J. W. [Signature] (M. D. or other) _____

Address 115 C [Signature] Date signed 5-9-44

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

24
0
0

1
LEVEL
District Health Officer No. 8:
District #1 Number
Date Filed 5-26-44

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

John S. Morton

Licensed Embalmer No. 4349

P. O. Address North Kan 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.