

FILED JUL 19 1944
Registration District No. _____

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:
6418 Summit St.,
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution no. (Specify whether
In this community 38 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson, 48
(c) City or town Kansas City, 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 6418 Summit
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x D

3. (a) PRINT FULL NAME Mrs. Flora Adams French
3. (b) If veteran, name war no. 3. (c) Social Security No. no.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 3rd
year 1944 hour 4:00 minute P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed,
6. (b) Name of husband or wife William L. French 6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased March 10 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1936 to July 3, 1944
that I last saw h. cc. alive on Jan 3, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death terminal arteriosclerosis
heart disease - coronary
sclerosis Duration 10 yrs.

8. AGE: Years Months Days If less than one day
78 3 24 23 hr. min.

Due to _____
Due to _____ 171 hr

9. Birthplace Illinois, (City, town, or county) (State or foreign country)
10. Usual occupation at home,

Other conditions terminal thrombosis 48 hrs.
(Include pregnancy within 6 months of death)
Chronic nephritis PHYSICIAN

11. Industry or business x
12. Name William Randolph Adams,
13. Birthplace Kentucky, (City, town, or county) (State or foreign country)
14. Maiden name Cornelia Davis, (City, town, or county) (State or foreign country)
15. Birthplace Ohio, (City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Philip A. French,
(b) Address 435 W. 57th Ter., K. C., Mo.
17. (a) Removal (b) Date thereof 7-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ottawa, Kansas,

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 _____

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 7-9-44 (b) H. E. Brown
(Date received local registrar) (Registral Signature)

23. Signature Joseph E. Salkin (M. D. or other)
Address 836 Prof. Bldg Date signed 7/4/44

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

MOTHER FATHER

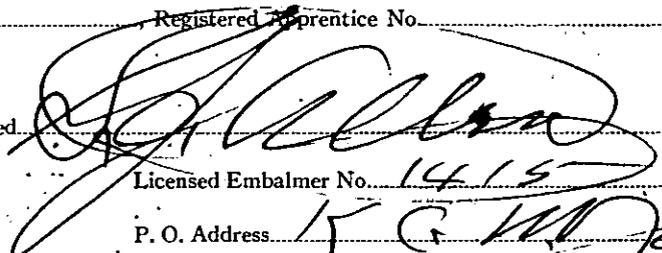
Dr. Joseph E. Welker,

*Trinity Lutheran
14 West*

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 
Licensed Embalmer No. 1415
P. O. Address K. G. W. Co.

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.