

FILED JUN 22 1944

Registration District No. **149**Primary Registration District No. **1002**Registrar's No. **2375**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kan City**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2700 Gray Crestwood
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **13 mo**
 (Specify whether
 In this community **20 years**
 years, months or days)

3. (a) PRINT
FULL NAME**Emma McFadden**3. (b) If veteran,
name war **no**

3. (c) Social Security

No. **none**

4. Sex **f** | 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **widow**
 6. (b) Name of husband or wife **George**
 6. (c) Age of husband or wife if
 alive..... years
 7. Birth date of deceased **Dec 20 1864**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 | **5** | **11** | hr. min.

9. Birthplace **Clowie** (City, town, or county) (State or foreign country)10. Usual occupation **Housewife**11. Industry or business **Dom**12. Name **George Johnson**13. Birthplace **Ohio** (City, town, or county) (State or foreign country)14. Maiden name **Mareah Kneeland**15. Birthplace **Mass** (City, town, or county) (State or foreign country)16. (a) Informant **De Verne McFadden**(b) Address **5312 Harrison**17. (a) **Rural** (b) Date thereof **6/3/44**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Mt Washington Cem**18. (a) Signature of funeral director **Geo. Mayberry**(b) Address **2315 Linwood**19. (a) **6-3-44** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kan City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5312 Harrison**
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No) **0**
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31**
 year **1944** hour **8** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **March 1,**
 1944, to **May 31,** 1944,
 that I last saw her alive on **May 31,** 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death

acute myocardial failure

Duration

30 minDue to **Hypertensive heart disease****1 year**Due to **Generalized arterial sclerosis****years**Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

93d

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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) (c) Means of injury

23. Signature **Theo. C. McHale M.D.** (Physician or other)Address **4620 Indep. Ave** Date signed **6-2-44**

7/11/53
4626

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 _____

Ray E Snow

Licensed Embalmer No. 2560

P. O. Address R. E. Snow

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.