

FILED AUG 2 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3007

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:
3812 WALNUT STREET
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
(Specify whether
 In this community 30 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County JACKSON
 (c) City or town KANSAS CITY 48
(If outside city or town limits, write "RURAL")
 (d) Street No. 3812 WALNUT STREET 8
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country None

3. (a) PRINT FULL NAME MRS. CATHARINE BRECKINRIDGE
 3. (b) If veteran, name war No
 3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month JULY day 20TH
 year 1944 hour 2 minute 10 A. M.

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife MR. CHARLES C. BRECKINRIDGE
 6. (c) Age of husband or wife if alive 30 years
 7. Birth date of deceased NOVEMBER 30, 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 18 1944 to July 20 1944
 that I last saw him alive on July 19 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 7 Days 20
 If less than one day hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage 7/15/44
 Duration _____

9. Birthplace ST. LOUIS COUNTY MISSOURI
(City, town, or county) (State or foreign country)
 10. Usual occupation AT HOME

Due to Cerebral arterio-sclerosis & malignant hypertension ?
 Other conditions Hypertensive branches 7/19/44

11. Industry or business _____
 12. Name SAMUEL RAYBURN
 13. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)
 14. Maiden name NANCY WALKER
 15. Birthplace ST. LOUIS COUNTY MISSOURI
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 6 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy X

16. (a) Informant Mrs. W. A. Beall
 (b) Address 3812 Walnut

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

17. (a) CREMATION (b) Date thereof 7-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation D. W. NEWCOMER'S SONS
 18. (a) Signature of funeral director D. H. Newcomer, son
 (b) Address 1401 BRUSH CREEK BLVD.
 19. (a) 7-21-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) _____
 Address 1012 Chestnut Blk Date signed 7/21/44

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

MOTHER FATHER

Professional Body

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..... *A. C. Newcome*.....
Licensed Embalmer No. *4043*.....
P. O. Address. *A. C. 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: