

FILED AUG 2 1944 749

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 **1733 Woodland**
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **55 years** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL") **8**
(d) Street No. **1733 Woodland**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Susie Huff Whisiger**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **3 Fe** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **2 Widowed**

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

7. Birth date of deceased **December 24, 1870**
(Month) (Day) (Year)

8. AGE: Years **73** Months **6** Days **22** If less than one day
hr. _____ min. _____

9. Birthplace **Nashville Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Malinda Huff**

15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Geneva Brookins**

(b) Address **1733 Woodland**

17. (a) **burial** (b) Date thereof **7/21/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **Stalins Bros**

(b) Address **1729 Lydia**

19. (a) **7-20-44** (b) **N. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **16th**
year **1944** hour **10:10** minute **P.** M.

21. I hereby certify that I attended the deceased from **July 10, 1944** to **July 16, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration _____

Due to **Cerebral Hemorrhage**

Due to _____

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **no**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) - 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 **7200 81st** Date signed **7-18-44**

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

MOTHER FATHER

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.....

J. Maxlove

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.