

**FILED AUG 23 1944**  
149

Registration District No. **149** 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:  
2714 Mersington  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether  
In this community 50 years \_\_\_\_\_ (Specify whether  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2714 Mersington  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** HALLA A. OYLEAR  
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Fe. 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife William J. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 14, 1870  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>73</u>	<u>4</u>	<u>25</u> hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business At Home

**MOTHER FATHER** 12. Name Austin M. Minturn

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

14. Maiden name Elizabeth Hobson

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

16. (a) Informant Charles G. Minturn

(b) Address 2714 Mersington

17. (a) Burial (b) Date thereof August 12, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director C. H. Blackman & Son  
(b) Address Kansas City, Mo.

19. (a) 8-10-44 (b) H. E. Brown  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month August day 9  
year 1944 hour 3 minute 45 P. M.

21. I hereby certify that I attended the deceased from 7-1- 1944, to 8-9- 1944  
that I last saw her alive on 8-9- 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Malaria Fever &  
Due to cardiac asthma

Due to Malaria + weakness  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 288  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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?

In \_\_\_\_\_ (Specify type of place)  
while at work? (e) Means of injury \_\_\_\_\_

23. Signature Amey Brown (M. D. or other)  
Address 2637 E. 29th Date signed 8-10-44

Duration

6 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

48  
38

11-15

Dr. Army Brown  
2637 E. 29th

NOV 21 1968

**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

*W.D. Blackman*

Licensed Embalmer No. *3639*

P. O. Address *R.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.**