

S. No. 2
M-5-43
y. 5-17-39
I X36671

FILED SEP 22 1944

Registration District No. **1002**

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

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:
3432 CHESTNUT AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1**
(Specify whether years, months or days)

In this community **19 YEARS**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON 41**

(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")

(d) Street No. **3432 CHESTNUT AVENUE**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **TI**

3. (a) PRINT FULL NAME **MRS OLEA, LYDIA, DERRINGTON**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NONE**

4. Sex **FEMALE** **5. Color or race** **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **EMRY, DERRINGTON**

6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **NOV 25 1882**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **31** year **1944** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **June 24**, 19 **44** to **Aug 31**, 19 **44**

that I last saw her alive on **8-26-44**, 19 **44**; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
61	29	6	hr. min.

Immediate cause of death **Generalized carcinomatous Primary site undiagnosed Probably Breast**

Duration

9. Birthplace **FOWA. I**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

Due to **50**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

12. Name **OWA F. J. HOWK**

13. Birthplace **SWEDEN 4**
(City, town, or county) (State or foreign country)

14. Maiden name **WOLFE CRANSON**

15. Birthplace **SWEDEN 4**
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations

Of autopsy

16. (a) Informant **EMRY, DERRINGTON**

(b) Address **3432 CHESTNUT KCMO**

17. (a) Burial (Burial, cremation, or removal) **Memorial Park** (b) Date thereof **9-5-44**
(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a)' Signature of funeral director **D. E. Newcomer's Sons**

(b) Address **1401 BRUSH CREEK BLYD.**

19. (a) 9-2-44 (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) (r) Means of injury

23. Signature **Woolftrap Deag** (M. D. or other)
Date signed **9-1-44**

Professional Reddy

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.

Signed

Charles H. Heston

.....
Licensed Embalmer No. *1767*

.....
P. O. Address *KC 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.