

FILED OCT 2 1944
1944

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **3773**

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:
St. Luke's Hospital,
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution **4 WEEKS**
(Specify whether
In this community... **all her life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson,** **47**
(c) City or town **Kansas City,**
(If outside city or town limits, write "RURAL")
(d) Street No. **Park Lane Hotel,**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Miss Eleanor McKenzie**
3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced... **Single**
6. (b) Name of husband or wife **no.** 6. (c) Age of husband or wife if alive **X** years
7. Birth date of deceased **April 21 1880**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	4	25	hr. min.

9. Birthplace **Missouri** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **at home**

11. Industry or business **X**

MOTHER FATHER { 12. Name **Alexander McKenzie**
13. Birthplace **unknown,** (City, town, or county) (State or foreign country) **9**
14. Maiden name **Anna Schell**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country) **9**

16. (a) Informant **Mrs. Anna McKenzie**
(b) Address **Park Lane Hotel, Kansas City, Mo.**

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof **9-18-44**
(Month) (Day) (Year)
(c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, Kansas City, Mo.**

19. (a) **9-18-44** (Date received local registrar) (b) **P. E. Brown** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September**, day **16th**
year **1944** hour minute P. M.

21. I hereby certify that I attended the deceased from **July 7** 19**44** to **Sept. 16** 19**44**
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis**
Due to **Hypertension**
Due to _____

Other conditions (Include pregnancy within 3 months of death) **83 b**
Major findings: 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? _____

t. While at work? (Specify type of place) (e) Means of injury **0**
23. Signature **P. E. Brown M.D.** (M. D. or other) **9/18/44**
Address **P. E. Brown** Date signed **9/18/44**

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

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

Dr. Boughnour

315 Alameda.

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 E. M. Plouffe

Licensed Embalmer No. 1848

P. O. Address 14. C. 2nd

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.