

FILED NOV 13 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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 K.C.H.  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 538 Main  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PATSY RUTH MARTIN

3. (b) If veteran, name war No

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24<sup>th</sup>  
year 1944 hour 5.25 minute 2 M.

4. Sex Female 5. Color or race W

6. (a) Single, widowed, married, divorced unknown

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: unknown  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years Months Days If less than one day

about 35 yrs hr. min.

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

Due to Ruptured aorta

Due to Pending

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation unknown

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy See Above

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

16. (a) Informant Coroner's office

(b) Address KC 710

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-27-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Springtown Texas

18. (a) Signature of funeral director D. E. Brown

(b) Address KC

19. (a) 10-27-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

23. Signature A. E. Vosker (M. D. or other) 10/28/44  
Address 238 McCoy Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

**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 *Della B. Logeton*  
Licensed Embalmer No. *4773*  
P. O. Address *15 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.**