

FILED NOV 14 1944
Registration District No. _____

Primary 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:
929 Forest Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **25 years** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mrs Lue Whitten

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

3. (c) Social Security No. **no**

4. Sex **Fe** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **Nov 17th 1867**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	II	I4	hr. _____ min.

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

10. Usual occupation **Rooming House Owner**

11. Industry or business **25 years**

MOTHER FATHER

12. Name **Marion Condit**

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

14. Maiden name **Gray**

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

16. (a) Informant **Mrs Hallie Greff**

(b) Address **Dayton Ohio**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **Nov 4th 1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Huntinburg Indiana**

18. (a) Signature of funeral director **Eylar Funeral Home**

(b) Address **1800 Linwood**

19. (a) **11-1-44** (Date received local registrar) (b) **T. E. Brown** (Registrar's signature)

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")

(d) Street No. **929 Forest Ave**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **31**
year **44** hour **2** minute **15** AM

21. I hereby certify that I attended the deceased from **1941**
days and nights to **Oct 31**, 19**44**

that I last saw her alive on **10-30**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **8 pm**

Due to **Hypertension also** **unk.**

Due to **Parkinson's Syndrome** **4 pm**

Other conditions **she had an exhausted**
(Include pregnancy within 3 months of death)

Major findings: Of operations **exhaustion** **PHYSICIAN**

Of autopsy **no 830**

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) **no**

(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 **T. E. Brown** (M. D. or other)

Address **3204 Colerain K.C. Mo.** Date signed **10/31/44**

Dr N.C. Speer
602 Packard

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

Glen C. Heck

Licensed Embalmer No. *4063*

P. O. Address. *1802 Linwood Blvd.*

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.